






Government  
Publications



Government  
Publications





Digitized by the Internet Archive  
in 2022 with funding from  
University of Toronto

<https://archive.org/details/31761114668429>











9557

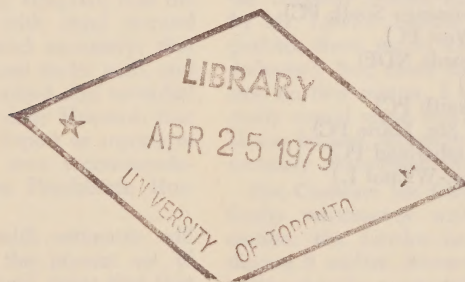
No. S-1

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Estimates, Ministry of Culture and Recreation

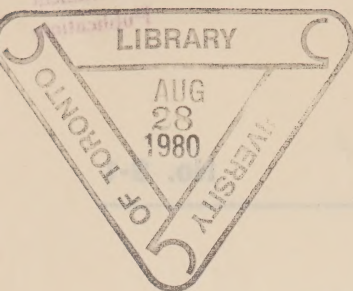


**Third Session, 31st Parliament**

**Monday, April 9, 1979**

**Speaker: Honourable John E. Stokes**

**Clerk: Roderick Lewis, QC**



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

### STANDING SOCIAL DEVELOPMENT COMMITTEE

**Chairman:** Gaunt, M. (Huron-Bruce L)  
**Vice-Chairman:** Kerrio, V. (Niagara Falls L)  
**Belanger, J. A.** (Prescott and Russell PC)  
Blundy, P. (Sarnia L)  
Cooke, D. (Oshawa NDP)  
Gigantes, E. (Carleton East NDP)  
Grande, A. (Oakwood NDP)  
Jones, T. (Mississauga North PC)  
Kennedy, R. D. (Mississauga South PC)  
Leluk, N. G. (York West PC)  
McClellan, R. (Bellwoods NDP)  
O'Neil, H. (Quinte L)  
Pope, A. (Cochrane South PC)  
Ramsay, R. H. (Sault Ste. Marie PC)  
Rowe, R. D. (Northumberland PC)  
Sweeney, J. (Kitchener-Wilmot L)

Hansard subscription price is \$15.00 per session, from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, 9th Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3. Phone 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.



## LEGISLATURE OF ONTARIO

MONDAY, APRIL 9, 1979

The committee met at 4:05 p.m.

**Mr. Chairman:** Ladies and gentlemen, I see a quorum. I should advise the committee that I have been informed that Mr. Lawlor will substitute for Ms. Gigantes today, Mr. Breagh will substitute for Mr. Cooke and Mr. Conway will substitute for Mr. Kerrio.

The purpose of today's meeting is to consider and discuss the estimates of the Ministry of Culture and Recreation. However, before we get to that, I believe Mr. Lawlor had a matter he wanted to raise.

### MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

**Mr. Lawlor:** Mr. Chairman, thank you kindly. This is about a preliminary matter that I am sure we can dispose of with alacrity. I would like to move a motion to the committee and the motion reads as follows:

Motion by Mr. P. D. Lawlor for the social development committee, pursuant to the referral of the annual report of the Ministry of Health:

Be it resolved that consideration of this report be concentrated on the decision to close Lakeshore Psychiatric Hospital; that the committee be provided with legal counsel and any other staff deemed necessary; that the committee hear witnesses under oath, and the proceedings be transcribed and recorded in the same format as the daily Hansard; that the committee presents a report or reports to the Legislature, with its own recommendations regarding Lakeshore Psychiatric Hospital."

**Mr. Chairman,** the health estimates will ensue immediately after the present set of estimates terminates. I would guess that that might be in a couple of weeks' time. I'm suggesting to this committee that we do the work with respect to the motion before the House and this present motion prior to launching into the Health estimates. After these estimates before us now have terminated and before you start on the Health estimates, I suggest a certain period of time be allocated to this Lakeshore situation.

I propose working with others to have delegations attend and present their cases. I think it is only fair that the members of this

House have a full assessment and understanding of the situation and be able to weigh the merits of the closing of that particular institution. Of course, it happens to be in my riding. I would ask for full accord from members of this committee with a view to achieving that objective.

**Mr. Rowe:** Mr. Chairman, I just want to clarify, first of all, that it should be held as part of the time allotted to the assessments of the ministry estimates.

**Mr. Lawlor:** My position on that is "no". That it is a separate and distinct matter that ought not to impinge upon the ministry estimates as such. It has content enough and I would ask the committee to consider this in isolation and not detract from the estimates as they come through.

**Mr. Chairman:** I think, Mr. Rowe, in the final analysis, that would be left with the House leaders to work out. Mr. Lawlor has recommended that it be dealt with as a separate item and not infringe on the total allocation assigned to Health. I think the total number of hours is 20. There were some preliminary discussions among the House leaders, as I understand it, having to do with the opposed motion and referral alluded to by Mr. Lawlor. I think it was suggested that perhaps there would be some time allocation deducted. But, there has been no final decision on that matter. I suggest to you that it really would come down to a decision of the House leaders, although this committee could certainly recommend that.

**Mr. Conway:** Mr. Chairman, I have no difficulty whatsoever with the intent of the motion. Mr. Lawlor had the opportunity to discuss it earlier. Some members of the committee may be presented with some difficulty initially, since it's my clear understanding from the House leaders that their view of such an enterprise is that the time allocated will be reduced on a 50 per cent basis applied against the Health estimates. We have 20 hours for Health estimates.

What I'm saying, Mr. Chairman, is simply this: Before the motion is put and voted on, I would like to have some clear indication from the House leaders as to exactly what kind of time constraints we are operating under. If, indeed, it is going



to be taken against the Health estimates, given the nature of the House debate at the present time, we only have 20 hours, and as I know the member for Lakeshore is well aware, I have quite a number of colleagues, and I'm sure so do other members as well, who would certainly like to talk about their own hospital situations. I think it would be unfair, notwithstanding the very important debate with respect to Lakeshore Psychiatric Hospital, to have that debate proceed to the total exclusion of any time that might be available for the other debate.

I guess what I'm saying is simply this: that I would not want to have the motion voted on until we have some very clear understanding from the House leaders as to what our time is going to be. I think the motion speaks to a very important specific hospital closure and it should be dealt with by this committee. I have no difficulty with that whatsoever. It is clearly the question of time constraint I would like to be certain of before voting on this. I want to know what it is I'm voting for, that's all.

**Mr. Chairman:** In essence, you would support Mr. Lawlor in the contention that no time be deducted.

**Mr. Conway:** That would depend, I suppose. We had one of these discussions last year. As members will recall, we spent six sitting days of this committee in dealing with the OHIP premium increase. That seemed to be sufficient time for a preliminary investigation of that tax matter. What I am asking for is just some clear understanding of how the House leaders view this with respect to the 20 hours in the Health estimates.

**Mr. Breagh:** There is a conflict in this which I'm not purporting to give you an easy answer to. In my view it's very necessary that this type of motion be put now and passed now for several reasons, not the least of which is the very practical thing that if we are to ask people to come before this committee we need to provide for them, and for the committee, some time to clear the decks and get ready for that.

So I think at its earliest convenience, which in my view is now, this committee must decide that this is what it wants to do, that we will do that this afternoon and begin the process of notifying people who might want to appear before the committee, identifying groups or individuals who may need some time to clear their schedules to get here.

If I have a fault to pick with the procedure we used the last time, it struck me

that we got into this investigation of a rather complicated matter in a bit of a hurry with not enough lead time. It's my intent to support the motion before the committee today for precisely that purpose; to give to the committee and to the people who might be interested in appearing before the committee sufficient lead time to clear their schedules and to arrange their briefs and to get things lined up.

The matter of how much time will be devoted to this I'm certainly very negotiable on. I want ample time to do it. I do not want to be rushed. I do not want three or four short sessions. We know that on certain days this House does not quite proceed as it normally does and you lose some time, a half hour to an hour some days.

I would not be unhappy with a starting position of six hearings, six three-hour sessions, as we had the last time. I originally thought 10 would cover it with no problem. Clearly I'm ready to negotiate on what kind of time we spend on that. It isn't my concern that this be a long drawn-out affair, but it is my concern that we give ourselves sufficient time to consider the many and complicated perspectives that will be put on the closure of the Lakeshore Hospital. That's my concern.

Again, I'm not happy with the notion that every time the House decides to have an investigation of this type, the House leaders then go off somewhere where none of us participate too actively—at best we get kind of second- and third-hand participation—and they decide what a committee will do. As you know, the committee I chair, procedural affairs, is looking at the way committees order their business. There is just a dramatic conflict in there where the rules say that a committee can virtually decide its own course of action, allocate its own time; there is nothing to prevent committees from hiring staff. The only problem is that the old brakes get put on when the House leaders enter the picture and they decide to order the estimates according to the standing orders and to allocate time and to divide half of what's been allocated for Health estimates—if we take 10 hours on this then five hours come off the Health estimates and all kinds of great and wonderful formulae take place. I don't envy the House leaders their job, but I put to the members of this committee, as I will to several other people around here, that there's a conflict there.

[4:15]

I believe that committees should be able to order their own business, should, at least, be able to establish the priorities. If there are practical matters that we all have to negotiate we're prepared to do that as we are on 95,000,000 other things around here, but I think that a committee has a right and an obligation to set its own course to decide what it wants to do, to recognize the practical problems of negotiating time, when it can sit and substitution and so on.

I just want this committee to say nice and clearly this afternoon that it thinks the closing of Lakeshore deserves careful scrutiny by a committee of this Legislature, it wants to look at why that happened and what was the rationale; that this committee wants to talk to the people who were involved in that decision-making process—and probably more importantly, in this case, the people who were not involved in the process of arriving at that decision—and we want to give to the people who work in and were serviced by that psychiatric facility the opportunity to appear before a committee of the Legislature and state their case. I suggest that we will set a precedent and this committee would serve the House extremely well if it did just that.

The forums that members have, during question period, and that members of the community have are limited and rather restricted and it's my view that a committee of this Legislature has an obligation to hear the public, to hear the people involved and to provide a clear rationale for the way we proceed, how we do that, how we conduct that kind of an investigation. We don't want a witch-hunt and we don't want to sensationalize, but we do want the facts. We do want to give the public at large an opportunity to present its opinions.

In my view, Mr. Chairman, the motion is fairly clear and fairly straightforward. We are laying out what the committee wants to do. I think we have all stated the kind of time constraints and scheduling problems that are there and we recognize those. I would not like to see the Health estimates diminished because of this but on the other hand I am prepared to proceed with this as matter of prime public importance and without delay. If I am to be successful at providing the kind of forum that I want the professionals, the community workers and the community at large to have, I have to be able to tell them well in advance that this is what we are going to do, to provide the staff time to advertise to the community, to talk to administrators and arrange occasions

when they could come here. That requires the committee this afternoon to make the simple decision of what we are going to do.

I think we have all stated the kind of problems that we see. Some of those things will get resolved by a process of negotiation. I think this committee has an obligation to say in no uncertain terms that this is what we want to do and I support the form that Mr. Lawlor has used to present that to the committee.

**Mr. Sweeney:** Mr. Chairman, I understand the mechanism of referring the annual report of the ministry to the committee but am I to understand with the use of the word "concentrated" on the third line that this is the only issue that's going to be discussed with respect to referring the annual report?

**Mr. Chairman:** That's right.

**Mr. Breaugh:** If I could just speak to that, as someone who is involved in the process of writing this out, the standing orders call for the referral of an annual report, that's the mechanism that is used. I think the obligation is on the committee to lay out for anybody who's concerned, what the main thrust of the thing is. It says "concentrated on the closure of Lakeshore Psychiatric" because that, in all honesty, is exactly what we want to look at. It cannot say "exclusively." It cannot say we sort all of these other things out which would forbid a member of the committee from passing other things but I would hope that the members are all clear that the focus of the committee's deliberations will be on the closure of Lakeshore.

**Mrs. Campbell:** Mr. Chairman, do I understand from what the member for Oshawa has said that he has stated we have to have public participation, with which I am in hearty accord? But is this committee then, by the wording of this particular resolution, saying it is not prepared to hear from those whose active-treatment beds have been cut—in one case, from some 78 to some 38 or some such figure? If you are interested in hearing from the public, why shouldn't there be some specific allocation of time, if you like, dealing primarily with the closure of a hospital; but not precluding these other people from being able to come to a committee and state their case on the closing of beds—to the detriment, as they see it, of the community? This is the problem I can foresee.

I would ask what solution there is. Everyone here, I think, is committed to the ques-



tion of Lakeshore—without question. But we can't surely forget, as a result of the annual report, all these other hospitals where people feel they would like to express their concerns to a committee.

**Mr. Lawlor:** To try to wind this matter up, and in answer to Margaret's comment, I had something to do with the wording, which was previously "restricted." I said, "No, you can't do it that way; you have to allow time for other people who have other problems, even if it is understood that the concentration would be on this particular hospital." It would be unfair to exclude, right off the cuff, the possibility of bringing others in. I would trust that it wouldn't be prolonged and that it would probably not involve too much.

In answer to Sean Conway, it is not going to be easy to line this up, particularly in the time period we have—I would think two weeks at the best—to inform the delegations and let them get their briefs ready. I would ask you to refrain from letting it get away from this committee without a decision today. That can go on rather indefinitely and we will never know quite where we stand. I have to get on with the thing.

All we're saying here, as I see it, is that in principle an investigation ought to take place. We are not setting down strict rules now as to the length of the time periods and regarding who will appear and who will not appear—all that kind of thing. We simply are beginning.

This is different from the OHIP thing; the OHIP was an omnibus debate ranging over the whole area of OHIP. This is a concentrated piece of business with respect to a single institution, which we should be able to handle adroitly and, I trust, with speed. In the light of this, I would ask that the committee address itself to this issue decisively this afternoon.

**Mr. Conway:** I certainly can appreciate what Mr. Lawlor has said in that connection. Having suggested, in the first instance, that this would be the proper way in which to handle the Lakeshore matter, I appreciate Mr. Lawlor's having accepted my basic and early proposal. I would just tell him that, in the absence of any direction from the House leaders or any kind of commitment as to time allocation, I am quite prepared to recommend to my colleagues that we accept this motion in principle; that is, so long as we understand either of two things: that a majority view here does not accept the principle of time being deducted from Health estimates, period; or we accept Mr. Breagh's

point that we generally agree before the motion is put.

I am not suggesting an amendment per se; I think we are reasonable people and that we can come to some general understanding here today. Mr. Breagh has indicated six sittings; that is fine with me. I just want to be clear about some sense of time and I think Mr. Lawlor can appreciate that. I know exactly the pressure on you and other Metro members. That is why I think this is a very legitimate inquiry. I want to make that as clear as I can, in so far as the time allocation is concerned.

So long as we ourselves can come to an understanding about this, I have no difficulty in recommending this motion to my colleagues. In the absence of some kind of understanding, I hope you can appreciate that people in Penetanguishene and indeed Huron-Bruce and other such places, where similar situations are occurring, will feel that they too have a case before this committee. It's just that sense of balance that I want to decide upon.

**Mr. Breagh:** Mr. Chairman, could I suggest a frame of reference for the time period? I am suggesting the last exercise the standing order was used on took six sittings of the committee, and we establish that as the bottom line. I would suggest to the committee that 10 sittings would be more appropriate, but we're clear then that what we're talking about is between six and 10 sessions of about two and a half to three hours each on that. Is that a reasonable compromise for you?

**Mr. Sweeney:** Is it part of the Health estimates?

**Mr. Conway:** What does that mean if we don't have an agreement from the health critics?

**Mr. Breagh:** I'm quite prepared to accept totally your position that it not be deducted from the Health estimates.

**Mr. Rowe:** None of it, are you saying?

**Mr. Chairman:** And you want a total of 10 hours, Mr. Breagh?

**Mr. Breagh:** I would suggest that's an appropriate amount of time to spend on this and related matters. I can suggest, if you want to consider it now or in the future, some variations of the new standing orders which, for example, allow the committee to form subcommittees that may do a lot of the work. For example, if you were seriously interested in forming subcommittees it would be possible to cover very broad geographic areas in the province or to use

the same number of sitting hours and hear many different kinds of things.

I'm really saying one simple thing. In my view, we should have 10 sessions and that should not be deducted from the Health estimates. I'm prepared to recognize that that's going to be subject to some negotiation, but that's my starting position.

**Mr. Conway:** I recognize the point about wanting to proceed as quickly as possible with this, but since none of us here has the authority of our House leaders, and since we've just left the chamber wherein agreements were not easily arrived at, with respect to one day sitting, much less others, could we just generally agree that we let the motion stand until no later than tomorrow so that all of us can confer with our House leaders to ensure that we have some kind of working agreement, since I think there is almost unanimous support for the intent of the motion?

I would certainly appreciate it not be put off for any more than 24 hours, but just so that when we do decide, we understand clearly where we stand.

**Mr. Lawlor:** I'll go along.

**Mr. Conway:** Is that agreeable?

**Mr. Lawlor:** It will come back up tomorrow.

**Mr. Chairman:** Are you ready for the question?

**Mr. Lawlor:** There's no question until tomorrow afternoon when we'll come back to it.

**Mr. McClellan:** At the beginning of the session.

**Mr. Chairman:** Is it agreed the motion be tabled until tomorrow?

Agreed to.

#### ESTIMATES, MINISTRY OF CULTURE AND RECREATION

**Mr. Chairman:** To get back to Culture and Recreation, I believe the minister—

**Mr. Grande:** Get back or begin?

**Mr. Chairman:** No. We are here, as I indicated initially, in your absence, Mr. Grande, to study the estimates of the Ministry of Culture and Recreation. We had an intervening piece of business with which we've been dealing and now we're back to the Ministry of Culture and Recreation. The minister has an opening statement.

**Mr. Grande:** Mr. Chairman, on a point of order: The 10 hours for the Culture and Recreation estimates begin at this particular point, do they?

**Mr. Chairman:** They begin now.

**Hon. Mr. Baetz:** Mr. Chairman, before we begin with the introductory report, I would like your guidance on a matter of procedure. As you and the members of the committee know, many of the agencies, such as the Royal Ontario Museum, the Heritage Foundation, the Art Gallery of Ontario, and so on, and others that have received transfer payments do come to these hearings and reviews. We would like to get some guidance from you at this time as to when you think those representatives might be called on.

[4:30]

Is it likely to be tomorrow? If it is, they can be on hand, but I think you will understand why we would not like to ask all of these outside agencies to be here for every hour of the sitting. If we could get some guidance as to when they might be expected to state their piece, it would be appreciated by them and by us.

**Mr. Grande:** I would be agreeable to the cultural agencies coming up tomorrow, provided the minister is agreeable to another bit of business that I think should be done prior to anything else in the Culture and Recreation estimates this year. I am referring to the incident that occurred this past week in which one of your top officials in the ministry resigned, making some very disturbing charges.

I like to think that if the minister is not going to acquiesce to a public investigation of those charges, as he so indicated in the Legislature, then at the very least that individual, Mr. Philippe LeBlanc, will be coming before this committee to present any evidence he might have, in order to clear the air of those particular charges. Mr. Minister, I for one do not accept the shrugging off lightly of those kinds of charges.

I had in mind, when my turn came up to speak, to present the motion to that effect and to state that Mr. Philippe LeBlanc would be before this committee tomorrow. If the minister agrees that should take place, I would suggest the cultural agencies could come before us on Wednesday. It depends, I suppose, on the vote in this committee whether that will take place or not.

However, I would suggest that before any other plans are made for this sitting, that is an item that has to be looked at and looked at hard. I think, Mr. Minister, you would agree with me that the people out there have a right to know whether these allegations have validity. I think that you, as the new Minister of Culture and Recreation, would want to feel assured that the credibility of



your ministry is not endangered in the public mind.

So with that, I will let the member from the Liberal Party speak on that.

**Mr. O'Neil:** Mr. Chairman, I have discussed this with some of our members and we feel the same—that we would like to see this gentleman come before the committee to be questioned and to clarify some of the cloud that has been placed on the ministry.

**Mr. Chairman:** As I understand it, the cultural agencies would come up under votes 3002 and 3003. Is that correct?

**Mr. Grande:** Mr. Chairman, if it is in order, since we're settling the matter of time allocation, I would put the motion before the committee. We may or may not want to debate it and vote on it, and then we can settle the other affairs as they come up.

**Mr. Chairman:** You have a motion?

**Mr. Grande:** Yes.

**Mr. Chairman:** Would you put it, Mr. Grande?

Mr. Grande moves that in the opinion of the social development committee Mr. Philippe LeBlanc be invited to attend the committee hearings and be asked questions and present to the committee any evidence and/or information which leads him to make the charges of "corrupt practices, inappropriate use of government funds and misuse of civil servants," that the materials and papers in the ministry on the race relations ad campaign, Welcome House, and the inter-ministerial committee on multiculturalism be provided to the committee, and that the citizenship and multicultural vote be the first vote we deal with tomorrow, Tuesday, April 10, or alternatively, four hours of estimate time be allocated to the citizenship and multicultural vote.

**Hon. Mr. Baetz:** Mr. Chairman and members of the committee, I did, of course, report in the House in response to a question that after having thoroughly discussed these charges with members of my ministry staff, I was convinced a public inquiry was not appropriate and was not necessary. I still feel that way. If the committee feels it is in any way going to help the review of our estimates to have Mr. LeBlanc appear before it, and if he agrees to come, obviously, I bow to your decision.

I would only like to say again I do not think it would contribute a great deal to the work of the ministry. I suspect there will be charges and counter-charges and I am not sure how much will be gained. I suppose in one sense, if I were thoroughly

selfish about this, I would be delighted to have Mr. LeBlanc appear tomorrow because neither I nor my ministry staff has a thing to hide. I think that will become very evident when Mr. LeBlanc appears tomorrow, or whenever he comes here. We can thoroughly document some of the charges he has made and prove they were, in fact, incorrect. If you want me to substantiate that by one or two examples right now to help you in your decision, I will be glad to do so.

**Mr. Kennedy:** Mr. Chairman, could we have that?

**Mr. Chairman:** The motion?

**Mr. Kennedy:** No, a couple of examples. I read the press reports, and I don't know a great deal more about it than that. It's a case. The resolution, your motion, goes beyond that of a disgruntled employee who didn't agree with ministry policy and so resigned. If there's more to it than that, let's have it.

**Mr. McClellan:** I think it would be appropriate to get into the details at the appropriate time, not at this time.

**Mr. Kennedy:** Well, we have got a vote on this.

**Mr. McClellan:** Mr. Kennedy, the motion is fairly clear.

**Mr. Kennedy:** The motion's clear but what's behind it isn't.

**Mr. McClellan:** I happen to have the letter of resignation which is self-explanatory. It seems to me there is an enormous amount of concern in the community, as I am sure the minister would be the first to concede. When a distinguished civil servant who has a long and honourable career with the government and is in a position of considerable responsibility as Mr. Philippe LeBlanc was, undertakes upon himself to resign publicly and makes a series of serious allegations or statements of concern, however you want to characterize them, then I think it is the business of this committee in estimates to review that matter as thoroughly as possible. I think it's entirely appropriate to ask Mr. LeBlanc, if he is willing to so do, to appear before us and to set out his concerns so those of us who have an interest in the success and credibility of the programs can determine whether there are major problems or not. I would ask the minister, if I may, to yield to his baser instinct: Be selfish.

**Hon. Mr. Baetz:** Mr. Chairman, I am simply saying that knowing what I do, I am convinced that with Mr. LeBlanc's ap-



pearance before the committee, there is going to be a good deal of embarrassment for him, which I have so far not spoken about publicly because of my interest in not getting into that thing. As I say, I could give you just one example now if it would help in any way your decision as to whether you want Mr. LeBlanc to appear or not. I can give you one example of a charge that was made that is totally unfounded.

**Mr. McClellan:** I am especially concerned that we have Mr. LeBlanc here. I don't know if there will be charges and counter-charges, but if there are I would hope that there would be the opportunity for any charges to be made in the presence of the counter-chargee. I don't want to get into that discussion today for precisely the reason that because Mr. LeBlanc is not here, Mr. LeBlanc does not have a forum to respond. I don't intend to raise his concerns today in his absence and neither, I think, should the minister. If we are going to raise them they should be raised when there is an opportunity for question and answer, proposition and response.

**Hon. Mr. Baetz:** Mr. Chairman, I simply state this so that tomorrow, when Mr. LeBlanc appears before the committee and I say certain things and reveal certain points of information, if they are embarrassing you will understand it was not I who wanted to carry on this debate in public any longer, that's all. I don't think any useful purpose is served.

**Mr. Grande:** Mr. Chairman, for the information of committee members who are going to be deciding on the question, I was in contact with Mr. LeBlanc and the information I got from him was that he was willing to come before the committee. I would assume he would accept, as an individual, the charges or the information that the minister might have. Mr. LeBlanc has definitely said to me he has nothing to hide and so he is willing to attend the committee if requested and invited. That is the way he phrased it.

**Mr. Kennedy:** Could you re-read the motion? Is there an allegation of corruption in that? If so, is that from the motion, or is that based on the letter of resignation from Father LeBlanc?

**Mr. Chairman:** Does the committee wish me to read the motion? If I can read Mr. Grande's writing, the motion read:

"In the opinion of the social development committee, Mr. Philippe LeBlanc be invited to attend the committee hearings and be

asked questions and present to the committee any evidence and/or information which leads him to make the charges of 'corrupt practices, inappropriate use of government funds and misuse of civil servants,' that the materials and papers in the ministry on the race relations ad campaign, Welcome House, and the interministerial committee on multiculturalism be provided to the committee, and that the citizenship and multicultural vote be the first vote we deal with tomorrow, or alternatively, four hours of estimate time be allocated to the citizenship and multicultural vote."

**Mr. O'Neil:** Before you put the question, I am just wondering, when we are asking somebody like this to come before the committee, whether we are giving him or the ministry sufficient time to prepare for this. I believe the estimates will be going on next Tuesday and I wonder whether we shouldn't postpone that vote 3004 until that time.

**Mr. Chairman:** Do you have any information, Mr. Grande, that Mr. LeBlanc could be available on very short notice?

**Mr. Grande:** Yes, Mr. Chairman, as far as Mr. LeBlanc has informed me, he would be available on short notice. The information he has—I assume he would just be as prepared as ever. I am sure the ministry expected something of this nature to occur this week and so they are prepared as ever. If it will serve any purpose, as far as I am concerned, either it will be tomorrow or else we will devote four hours of estimate time, and I really don't have any preference which. I would be amenable to having the four hours on this thing on Thursday or early next week. It doesn't make any difference to me.

**Mr. Chairman:** It couldn't be on Thursday; it could be on Wednesday.

**Mr. Grande:** Wednesday, yes, because Thursday we are not sitting.

**Mr. McClellan:** Why don't we schedule it for Wednesday?

**Mr. O'Neil:** Mr. Chairman, I have some problem with Wednesday, and I would certainly like to be here if Mr. LeBlanc comes before the committee. Because of a previous engagement which involves some legal matters, I wouldn't be able to be here on Wednesday.

[4:45]

**Mr. Kennedy:** Is this liable to spread to other witnesses? I don't want to delay things, but it seems to me there are very serious allegations here. Does this committee have the power to swear witnesses? Should this

be done? Might Mr. LeBlanc want to bring in others to support his claim? Where are we going to end up in this?

I'm sorry that I don't know more of the background as it could be helpful. These thoughts come to me, and I think the committee might consider them and take them into account. We may be into more than just having a visit for an hour from Mr. LeBlanc.

**Mr. Chairman:** We do have the power to swear witnesses, Mr. Kennedy, if the committee so wishes. Frankly, I don't like to do it any oftener than one has to, but we certainly do have the power.

**Mr. Blundy:** Mr. Chairman, I think the statements that have been attributed to Mr. LeBlanc are worthy of his appearing before this committee. In view of the fact that Mr. LeBlanc has said he would be prepared to come at any time, we ought to have that matter handled tomorrow to get it over with so we can go on with the estimates. I would be in favour of having him appear tomorrow.

Motion agreed to.

**Hon. Mr. Baetz:** That means that the agencies will be called in here Wednesday.

**Mr. Chairman:** The agencies would come on Wednesday and Mr. LeBlanc tomorrow. That is the wish of the committee.

**Mr. Grande:** Mr. Chairman, we do have 10 hours. We had the agencies before us last year. As far as I am concerned, we don't need to have those agencies before us this year. There is no need to take a look at all the votes of the Ministry of Culture and Recreation.

**Mr. Chairman:** That may be so, Mr. Grande. There may, however, be some members on the committee who would like to have a word with one or more of the particular agencies.

**Mr. Grande:** Of course, I was speaking for myself.

**Mr. Chairman:** I understand.

**Mr. O'Neil:** It may be that the NDP critic is a little more familiar with some of these agencies than I am as the new critic for the Liberal Party. I feel I would like to have these agencies here in case there are certain votes on which we would like to ask some questions.

**Mr. Chairman:** Can we agree then that we will have Mr. LeBlanc tomorrow and the agencies on Wednesday?

Agreed to.

**Hon. Mr. Baetz:** Mr. Chairman, in submitting this introductory statement, we have

this year a somewhat longer statement to make than in past years. I would hope that in proceeding in this way we may have less to say in the course of the discussions—or more maybe—and facilitate the procedure.

In submitting the budget estimates of the Ministry of Culture and Recreation to the standing social development committee, I would like to highlight some of the activities of the past year and more importantly to identify some of our salient thrusts during the current fiscal year.

My ministry has now been in operation for four years. What began as a somewhat eclectic assortment of programs is gradually being orchestrated into an integrated, even though wide-ranging and multifaceted, ministerial program. Our basic goal can be summed up as the enrichment of the quality of life for the people of Ontario. This goal, which by its very nature can never be fully reached, is pursued through several major channels which are reflected in the organization of our estimates summary now in hand: They include heritage conservation; arts; citizenship and multiculturalism support and, closely allied to that, libraries and community information; and sports and fitness.

One cannot fully appreciate our present society, its values and dynamics without some understanding of our history. It seems therefore only logical that this ministry should encourage in a variety of ways the conservation of our heritage. Our heritage conservation program both responds to and stimulates a growing interest among Ontarians in their heritage. During the year, approximately 275 buildings were identified as heritage buildings, bringing to more than 780 the number of properties in Ontario now designated as having heritage value.

Archives are everywhere recognized as a citadel repository of our collected historical documents, and it is therefore with considerable satisfaction that we have seen the archives of Ontario continue to grow and progress. During the year, the archives gained some excellent acquisitions, including the most significant collection of Canadian architectural drawings, the J.C.B. and E.C. Horwood collection of drawings by 55 architects for more than 1,200 buildings over a 135-year span from 1829 to 1964, totalling more than 10,000 items, most of which cover the period up to the First World War.

Another event of significance was the publication during the year of the first overall history of Ontario, entitled *Ontario Since 1867*, by Dr. Joseph Schull. The historical



publications series will continue with the planned publications in 1979-80 of two manuscripts—the history of pre-Confederation Premiers, and a biography of Sir Oliver Mowat—and with further work on an economic history of Ontario and federal-Ontario relations.

Our work in heritage conservation seeks to endow the people of Ontario with a knowledge and appreciation of 11,000 years of human settlement here. Whether through the future development of our provincial archives, the acquisition and protection of heritage properties, and archaeological and museum support, or historical summaries in books and manuscripts, we should pursue this goal with steadfast excellence rather than careless haste.

The ministry support of the arts covers an impressive array of arts and cultural organizations, ranging from well-known institutions of not only provincial but worldwide acclaim, such as the Art Gallery of Ontario, the Ontario Science Centre, the Toronto Symphony and the National Ballet, to 34 local art galleries, 30 local symphony orchestras, and thousands of individuals and agencies assisted through the Ontario Arts Council.

At the risk of appearing immodest, and perhaps even offending some Canadians living in other provinces, I do feel it can be stated both correctly and appropriately that Ontario has become the cultural centre of at least anglophone Canada.

I do not claim that this has been achieved solely through the efforts of the Ontario government. Obviously there has been help from the federal government, local governments, non-governmental sectors; and, above all, there are the contributions of the artists themselves. Nevertheless, it is the growing, substantial and consistent level of support in recent years, as well as the arm's-length policy between my ministry and the artists, that has been conducive to creating the necessary social and cultural climate in which artists can best express their creative talents.

I am fully aware, as are members of the committee, that the arm's-length approach has its inherent hazards. Not the least of these is providing support for some agencies or some individuals whom the general public and we, their political representatives, might feel constrained to treat with less understanding and tolerance than do the peers of the artists themselves, the people who are making the judgement whether they get help or not.

Although much of our cultural life is centred on Metro Toronto and the larger urban areas throughout Ontario, hardly a town or village in the entire province has failed to benefit from this healthy growth in our arts and cultural programs through such programs as Outreach.

Our arts and cultural development has achieved such a level of excellence and breadth that I believe that the time has come when we must now, in an organized manner, make it more available to more people outside of Ontario and indeed beyond Canada. To this end we are planning during 1979-80 to assign to Ontario House in London, initially on a temporary basis, an officer of my ministry who will be seeking ways and means to bring more of Ontario's artistic and cultural products, including visual arts, films, et cetera, to the people of the United Kingdom.

My ministry will also be working with the Ministry of Industry and Tourism and arts organizations, especially in Metro Toronto, to bring organized cultural tours from the United States to Ontario. We are confident that we have excellent cultural commodities to offer here in Ontario. I cite, as only an example, that Toronto now has more live-performance theatres than any other city in North America except New York.

One of the Ontario highlights in our cultural lives will be the showing of the Tutan-khamun treasures at the Art Gallery of Ontario in November. It will not only enhance our cultural life but it is a further indication of its advanced development.

I believe the primary responsibility for fostering our Canadian cultural industries rests with the federal government. After all, it has primacy in the areas of taxation, international tariffs and international agreements. Nevertheless, Ontario has a particular responsibility because so much of Canadian cultural industry is located here. We have and will continue to assist the cultural industries in a number of significant ways.

To assist the development of the Canadian film industry, the arts division of my ministry provided support to the Festival of Festivals, which attracted an audience of over 80,000 people, as well as contributing to the successful international animation festival in Ottawa and to the Canadian film awards.

Another major effort to promote our Canadian cultural industries is our very innovative Half-Back program. Last year, 1,200,000 non-winning Wintario tickets were redeemed for the purchase of 225,000 books by Canadian authors and 100,000 subscrip-



tions to Canadian magazines. This year, we have allocated \$4,000,000 in a similar Half-Back program, this time for a five-month period, to promote Canadian recordings and Canadian films.

An important cultural agency in my ministry is TV Ontario. We continue to review the policies governing this agency in order to determine its most appropriate role. I am especially determined that it should not do those things that CBC should do and neglects to do, perhaps because of ratings or bad planning. Because of the continually escalating rate of technological progress, long-range planning in TV is not only more important, but far more difficult.

We will, during the course of the year, be studying an interministerial report that has recently been completed. Among other matters to be considered will be that of additional sources of core financing, including more non-governmental sponsorships. I believe it is unrealistic in the foreseeable future to expect the Ontario government to provide the sole core financing to maintain TV Ontario at its present level of excellence and, as well, expand its viewing coverage to cover all of populated Ontario. We are particularly aware that areas such as Grey-Bruce and North Bay are not now covered, and I will diligently pursue ways and means with TV Ontario during this fiscal year to close these remaining gaps. Likewise, we will examine ways and means to expand radio station CJRT's listening audience.

In the meantime, TV Ontario continues to produce high-quality programs in the educational field. A prime example is *Read Along*, which is now not only a favourite with Ontario's children aged five to eight, but is the most widely used program teaching children how to read in 19 states in the USA. I've been told that Mississippi children are learning to speak with Ontario accents.

TV Ontario is likely the largest producer of educational programming on this continent and has produced a series of 52 shows, which has been purchased in the USA at top prices. While this may be cultural imperialism in reverse, it is something about which no one seems to be complaining.

The arts have never been entirely self-supportive in any civilization. It is not likely they will achieve this status today. Nevertheless, with growing participation in the arts by a larger segment of our population and with high-quality performance and good marketing, I believe the cultural agencies in Ontario are in a reasonably good economic

health. This is not to suggest we are oblivious to some of the financial difficulties some of our major cultural institutions are experiencing in maintaining their present level of service to the public in terms of quality and quantity.

For the decade ahead, government's role is to help consolidate what we have reached rather than foster further expansion. I am happy to point out that as our estimates show, we've been able to avoid the severe cutbacks applied to the cultural agencies by the federal government. We've been able to provide additional funds to our agencies largely by cutting back some internal ministry programs and administrative areas. This is as it should be; excellence in the arts is neither achieved nor maintained by even the best bureaucracy in the world—and we think we have one in Ontario—but by supporting the arts and their agencies.

[5:00]

**Mr. Grande:** Have you got the best bureaucracy in the world? Is that what you're saying?

**Hon. Mr. Baetz:** I think so. You'll find out tomorrow.

Our activities in the field of citizenship and multiculturalism, under which I am also including libraries and community information, is as widespread and varied as are our support and activities in the arts.

Members should be reminded that section 8(a) of the Ministry of Culture and Recreation Act, 1974, states the minister "shall advance and encourage the concept and ideal of full and equal citizenship among the residents of Ontario." It takes little imagination to recognize the "slightly unattainable" breadth of that mandate. Particularly in a multicultural society and one with many first-generation citizens, the idea of full and equal citizenship presents an onerous challenge to any government. At the most basic level, it requires a helping hand for the newcomers to our shores. The challenge is especially great when these people are penniless refugees.

It is relevant to note at this point that our government's policy continues to place primary responsibility on the federal government for the establishment of quotas and final admission of immigrants, including refugees. But we are increasingly consulting with the federal government, prior to their decisions, because provincial governments, especially Ontario, as one-third of all immigrants to Canada settle here, inevitably become involved in providing services to refugees upon arrival as well as later on.

We believe that Canada, as a member of the world family of nations, cannot callously cast a blind eye on the plight of refugees and it should join in with other nations in admitting its share. At the same time, in the interest of healthy economic and social development here in Ontario, the numbers of immigrants admitted should remain within not only the limits of economic integration but also of public acceptance.

We feel in this respect Ontario has once again acted responsibly in accepting a fair share of the unfortunate Vietnamese "boat people." During this fiscal year, we will be prepared to welcome to Ontario as many of the 5,000 Vietnamese refugees coming to Canada as wish to settle in our province. We expect that between 2,500 and 3,000 of them will take up this offer. In addition, Ontario will settle about half of the 5,000 refugees coming to Canada from other countries. To meet increased activities in this area it will be noted we have added \$155,800 to the estimated expenditures for the newcomer services branch for refugee settlement.

**Mr. McClellan:** Would you accept the quota of 5,000, is that what you're saying?

**Hon. Mr. Baetz:** We don't set quotas.

**Mr. McClellan:** You are not challenging it?

**Hon. Mr. Baetz:** No, we don't set quotas, the federal government sets quotas.

**Mr. McClellan:** But, you are not challenging it.

**Hon. Mr. Baetz:** Read back two paragraphs.

Pursuing the ideal of full and equal citizenship among other things requires equality of access to information about the services provided by this government. We continue, therefore, to support 50 community information centres across the province. To help them improve their service to the public we have introduced a common statistical recording and analysis system.

For newcomers and those who have not yet mastered the English language, equality of access to information requires special services. Commencing this fiscal year we intend to pursue this objective more vigorously than heretofore. We will be bringing together into one more readily accessible facility at the corner of Dundas Street and University Avenue in Toronto, the ministry's multilingual resources, its direct services to newcomers and a number of its citizenship development programs. This new Ontario citizenship centre, Welcome House, when fully developed will provide information

about, and access to, the services of this government in about 25 languages in person, by telephone or by mail.

It will also make our translation and interpreter services available to other ministries. It will house all the direct services now provided at Ontario Welcome House and the translation services bureau. It will develop new initiatives to help agencies and institutions in the community serve more effectively people of all ethnocultural backgrounds.

Admittedly, this service will most help only those newcomers to Metro Toronto. However, because more than 75 per cent of all immigrants coming to Ontario settle in the Metro area, we feel justified in taking this first major initiative here. The benefit gained through this experience will enable the ministry to evaluate the feasibility of extending such services to other parts of the province, as needed, through the ministry's regional office.

As a province, we are officially committed to a policy of multiculturalism. I suspect and believe that the value of a multicultural society is increasingly being perceived by the vast majority of our citizens. Nevertheless, in a society where these differences in ethnic communities and cultures are deliberately preserved as a matter of conscious policy, the potential for racial tension and misunderstanding can be greater than in a homogeneous society.

This is especially the case in a rapidly changing social and cultural environment, such as ours in Ontario. To this end, we have supported and will continue to support programs designed to enhance intercultural and racial understanding. Priority will be given to potential flash-point areas, communities that are undergoing the most rapid change in their ethnic composition, such as Metro Toronto and parts of its outer area, as well as Ottawa and urban centres in southwestern Ontario.

Through a public educational program with billboards and radio ads within Metro and throughout Ontario, as well as with pamphlets, we are currently stressing the theme "Ontario—from different pasts . . . a common future." We are committed to the view that a healthy multicultural society must be a positive and dynamic organization that must function in the spirit of human brotherhood.

Of course, the government must ensure a solid legal framework to guarantee human rights. This ministry's focus, however, is on the development of full and equal citizenship, a concept that relies on the law and



legal rights only as a last resort or as a safety measure. Our ministry work in multiculturalism is therefore preventive rather than therapeutic. A lack of headlines we feel reflects success rather than failure in achieving our goals.

One cannot speak about citizenship and, above all, the ideal of full and equal citizenship without special comment about our original citizens. In considering the estimates of my ministry, it is crucial to recall the Ontario government's policy and practice with respect to the delivery of services to native people. The Ontario government does not have, as you all know, a department of Indian affairs, but provides services to native people directly through every line ministry.

In order to co-ordinate activities and provide a focal point, in 1976 cabinet appointed a minister responsible for native affairs for dialogue with representatives of Indian agencies. He is the Provincial Secretary for Resources Development (Mr. Brunelle). He is advised by an internal committee of deputy ministers, the advisory committee on native affairs. The role of the minister is to facilitate the development of native policy and the delivery of services to native people and to ensure that communications are kept open between Ontario and the major status Indian organizations. As Minister of Culture and Recreation, I have been delegated the responsibility for providing a focal point for communications between Ontario and the off-reserve native organizations.

The native community branch is one of many services the Ontario government provides to native people. The branch as a consultative agency working with native groups tends to be primarily concerned with the development of human resources and leadership in the native community. Through the branch field staff, community development assistance is provided to local native communities. In addition to the staff resources of the branch, a grants program provides project funding to a wide variety of native-initiated projects and activities.

The branch also functions to assist native people in gaining access to the provincial government. In this manner, native people receive the full range of expertise and services available from all relevant line ministries. In conclusion, the role of the branch is not to deliver provincial services to native people, but rather to assist native people in taking full advantage of the resources and services available.

With this responsibility in mind, I have established two committees this year. One

is with the Ontario Metis and Non-Status Indian Association to study the question of the rights of the Metis. The other is the task force on the urban native, requested by the Ontario Federation of Indian Friendship Centres. This latter committee is to respond to the emerging phenomenon of migrating native people who are moving in increasing numbers from the more remote parts of the province to the cities and towns of Ontario.

**Mr. McClellan:** Emerging phenomenon?

**Hon. Mr. Baetz:** It is escalating, as the statistics will show. It has been going on for a long time but it is escalating—which is another way of saying emerging. The native population of Toronto, for example, is estimated at between 20,000 and 40,000. A clearer estimation will come after the next federal census.

**Mr. McClellan:** That is another way of saying you haven't done anything for the last 10 years.

**Hon. Mr. Baetz:** In closing this discussion of citizenship and full and equal access to government services, I would particularly direct the committee's attention to the work of the Council for Franco-Ontarian Affairs. The council provides an invaluable liaison between ministries and Franco-Ontarian groups to improve our sensitivity to the needs of Franco-Ontarians.

**Sports:** The veritable explosion of interest and activity in the field of culture and the arts has, if anything, been more than equalled by the activities in sports, fitness and recreation. My ministry, which is responsible for amateur sport, not only has been able to respond to this increased interest in fitness, sport and recreation, but has provided a healthy stimulus to this participation. Our input has been largely through the more than 80 sports governing bodies in Ontario, relying on them to govern themselves and their activities. As in the arts, so in sports we believe government support is best given "at an arm's length."

For some years, the sports-governing bodies have been financially assisted through proceeds from the Olympic lottery. This year, the ministry will be providing approximately \$800,000 to replace those lottery funds which are no longer available. This support will not mean an increase in total funding for the sports governing bodies, but will ensure a solid foundation of provincial support for the further development of amateur sport in the province. The sports governing bodies will also be assisted in carrying out their programs better as they



move to bigger facilities with the continued support of our ministry.

Among all the sports, ice hockey continues to be in a league of its own. In recent years there has been growing concern about certain aspects of life in the world of hockey, especially incidents of violence and brutality. This has evoked some reaction that government should step in. As the members of the committee realize, my ministry's decision has been not to become directly involved but to work through an independent agency of my ministry, the Ontario Hockey Council, which was created partially in response to the William McMurtry report on violence in hockey a few years ago.

Questionnaires have been distributed to more than 90,000 parents of minor hockey players in Ontario, asking them to assess the quality of hockey experience available to their children. The questionnaire explains the council's purpose is to help make hockey a positive learning experience and fun for players, parents, coaches and officials. We believe that in ascertaining for the first time the aggregate viewpoint of the parents, we are reaching that sector of the population which has the greatest direct interest in hockey and the wellbeing of the players.

The collated information and its analysis derived from the questionnaire will serve as a basis for further discussion at some 25 to 35 open forums to be held throughout Ontario. Before next year's hockey season opens, the amateur hockey community should have a clearer indication as to the major concerns and be in a position to take whatever specific steps are required to deal with them.

We are working through the Ontario Hockey Council because we believe that an arm's-length approach that stresses self regulation and self government will in the long run be the most effective way to eliminate violence in amateur hockey. We believe neither the provincial government nor the federal government should become directly involved in regulating amateur hockey except as a last resort.

In another area of amateur sport, Ontario missed by one point winning the Canada Winter Games trophy at Brandon, coming in second to Quebec. While this was a disappointment to some, there was more widespread concern and some surprise expressed at the relatively small number of gold medals won by Ontario athletes. It is therefore timely to recall that a principle of our grants program in sports is to foster participation rather than to stress elitism.

We continue to believe the primary government responsibility for the development of national- and international-calibre athletes rests with the federal government in so far as it rests with any government. In the meantime, our policy of widespread athletic participation in sports is everywhere apparent. A record number of 2,300 athletes, coaches and managers participated in the Ontario Winter Games in Kingston last December.

[5:15]

Increased participation in sports is also reflected in still another significant manner. The Ontario Games for the Physically Handicapped will be held once again this year in Oshawa for four categories—the blind, the amputee, wheelchair and cerebral palsy.

No statement on my ministry's program would be complete without comment on Wintario. It supplements and complements virtually every sector of our wide-ranging activities. To better reflect this situation in our estimates, Wintario's transfer payments formerly included without program differentiation in vote 2809 have been reallocated to each regular estimates program.

Separate Wintario administration budgets and expenditures accounts have been eliminated and integrated with regular ministry direct operating expenditures, where appropriate. An accounting allocation of direct operating expenditure costs pertaining to Wintario administration will, however, be made at the end of each fiscal year and reported in the public accounts of Ontario. This approach to estimates and accounting for Wintario has been recommended by the provincial auditor and implemented with the approval of the Management Board of Cabinet.

The historical comparative data included in the estimates in respect of 1978-79 and 1977-78 have been restated to include Wintario grants and administration in the operating programs, on the same basis as the integrated approach for the 1979-80 estimates.

As members of the committee know, the capital part of Wintario is now under review. It would be premature to speculate on the ensuing recommendations. I am confident, nevertheless, that Wintario funds will continue to be dedicated to the development of cultural, recreational and sports opportunities in Ontario. The impact of Wintario's funds on these fields in the past several years has been highly significant in improving the quality of life in Ontario.

The capital priorities review has been designed as a means to re-evaluate capital investment in this field and explore specific alternatives for the future. Broad public consultation is being planned in two phases, first in May and June, and then in the fall. During the spring consultation, input will be solicited from a broad cross-section of groups and individuals and in addition, personal interviews will be arranged between ministry field consultants and every MPP and municipality in the province.

Program staff will meet with representatives of various provincial groups that relate to this ministry, and through the use of a consistent questionnaire format, we hope to be able to collect the views of a great number of people in a manner that will be useful to the review process.

It is difficult to measure the success of our capital program in quantitative terms. Indeed, the measurement of all our programs is hampered by the lack of formal social indicators. However, we can certainly see, hear and feel. We can sense the vitality of our cultural progress, our progress in achieving racial harmony, increasing public involvement in recreation and fitness, and progress in opening the doors of government to the disadvantaged.

At a time when constraint is a popular theme, it is too easy to think that economic development and the maintenance of health and social services are ends in themselves. Vital as they are, they are only the means to foster human development, the fullest manifestation of which is seen in the flowering of our culture and in the participation of all people in a dynamic, creative society.

Mr. O'Neil: Mr. Chairman, Mr. Minister, first of all, as I mentioned in previous comments, I have just taken over as critic for the Culture and Recreation ministry. A lot of this is new to me yet, so I have some opening statements I wish to make. I plan to ask a fair number of questions as we go through the different votes and it is a bit of a learning process for me.

I am excited to have recently been appointed as Liberal Party critic for culture and recreation because our party wants to work to strengthen the policy areas in the ministry dealing with multiculturalism, sports, fitness and the arts.

In the past, lottery grants gave this ministry its high profile, while we feel other functions of the ministry were neglected. Now, with a new minister and a somewhat dismal lottery revenue picture, it seems

timely to review the direction or lack of direction evident in this ministry.

I have mounting concern about the minister's grip on the ministry portfolio. It may be that he is new and trying to get a hold on it himself, but since his appointment last fall I have seen evidence that he is not informed on the issue of the day. He is, in fact, not in control of decision-making in the ministry. This, hopefully, will change.

I would like to mention some specific examples. We feel there was a terrific lack of communication demonstrated between the minister's office and the Ontario Educational Communications Authority over the showing of the special program *The Jesus Trial*. The minister tried to stop broadcast of the series on the basis of hearsay. He publicly condemned the OECA's efforts when he hadn't even viewed the series himself. He did the same thing with the *Connections* show. It is our feeling that before comments were made they should have been reviewed by the minister. The minister should at least refrain from making comments until he has had a look at the shows.

The minister has been completely mute, however, in the case of the outrageously bigoted publication, the *Metropolitan Toronto Police Association* paper *News and Views*. The minister was also quick to voice an opinion contrary to the intention and subsequent action of the Ontario Arts Council in the case of the grant money for the gay magazine *Body Politic*. Decisions of the Ontario Arts Council are to be strictly free of political influence; that is why it is an arm's length agency of the ministry.

While I am on the subject of the Ontario Arts Council, it is obvious, from the fiasco with the Kensington Art Association, that the ministry has no way of controlling or enforcing the proper use of ministry grant money. I will have some more to say on this later, but I would like to note that even before the KAA disappeared with profits made on grant money, your ministry had no idea that it was funding the publication of a terrorist magazine, not until a Toronto newspaper broke the story.

We are still quite interested to know whether any of this money has been recovered by the ministry and where that stands.

I am quite curious as to why your colleague, the Minister of Consumer and Commercial Relations (Mr. Drea) has appointed an athletic commissioner, Jim Vipond, former sports editor of the *Globe and Mail*, to regulate and license wrestling and boxing,



when just such a function is performed by your own ministry through the person of Mr. R. Wittenberg. For many years now, he has administered the office of the athletic commissioner and has overseen the application of the Athletics Control Act, a piece of legislation which actually sets forth the mandate to license and regulate professional and amateur boxing. I am miffed as to why Mr. Drea is setting up a parallel agency to perform the same function as your ministry's agency. Not only is it a waste of taxpayers' money and disregard of your ministry's mandate, but it appears that your power as minister is far from consolidated.

I might mention at this point that I attended—it is a bit of a plug for the Ontario boxing industry in the province of Ontario—their “do” in Belleville, Ontario, yesterday and Saturday. The calibre of the organization, and of boxers and boxing in Ontario, is certainly to be complimented.

Within your own ministry, you have apparently forgotten that you have funded and operated the Ontario Hockey Council since 1975 to investigate violence in amateur hockey. While its output has not been prolific, nor its profile terribly high, I hardly see the need to launch yet another investigation into violence in amateur hockey, as you undertook to do just a week or so ago.

If your concern is so great, perhaps you could simply have made certain that this council was performing at a suitable level to satisfy the public and your personal concern.

Finally, and most important, on a matter which we touched on earlier today, I would like to suggest that the most damning evidence you have lost your grip on your ministry are the very disturbing allegations of corruption and manipulation made by the recently resigned director of the multicultural development branch. Here is a man, we feel, of impeccable integrity, a Dominican priest who is well respected in the community and among his peers for his efforts to make Ontario a more harmonious multicultural society. Yet it is quite certain that your ministry is being used by the Premier's (Mr. Davis) office to further highly political and partisan goals. His five-page letter of resignation to you, dated April 5, outlined various instances of using civil servants of your ministry to carry out orders or directions emanating from outside the ministry.

I quote from page four of his letter: “I consider that what is happening in the ministry is a totally unacceptable and corrupt practice. It represents, in my view, an in-

appropriate use of government funds and a misuse of civil servants.” There is much more I want to discuss on this issue but right now, at the outset of these estimates, I would like to call for, as has my NDP colleague, the appearance of Mr. Philippe LeBlanc before this committee. This is too serious an issue for us as legislators to ignore; and I am sure other ministry personnel, perhaps even yourself, would like to be relieved of any implication of complacency in so-called corrupt practice, if, in fact, Mr. LeBlanc's allegations are unfounded.

As I say, we are pleased that it is hoped Mr. LeBlanc will appear before the committee tomorrow. I think it offers a chance to the members of this committee to question him, and for the ministry to put forth their points on this too. I know that the minister, to be fair, commented in the Legislature that no discussion or no meeting was ever asked for by Mr. LeBlanc with the minister; I feel, Mr. Minister, this will possibly clear up some matters we all have questions about.

Beyond these rather specific concerns I have about the operation of the Ministry of Culture and Recreation, I would like to point out that I think the ministry provides a good forum and focus for arts, sports and multicultural activities in Ontario. In the next year, there are a number of activities I would like to suggest be undertaken, unless, of course, the minister can assure me that they are already in progress.

First of all, I would like to see some solid research done on the positive benefits of arts and cultural development. Mr. David Silcox, Metro Toronto's very able commissioner of the arts, produced some time ago—I believe it was in 1974—a convincing paper in support of more arts development. Unfortunately, he had to rely on statistics from the United States to prove how every subsidized arts dollar generates many times its value in related entertainment industries.

It is this kind of substantial argument that I think can win over public support for the arts community. It would be well worth the ministry's time, I feel, to promote the arts through publication of this kind of research and by subsequently dispelling the perception that the government is merely paying welfare to artists.

Furthermore, I would like to see the Ontario Minister of Culture and Recreation meet more frequently with his federal and municipal counterparts to iron out problems in operation procedure and in overlaps or gaps existing between governments. The first of these conferences should not be delayed



beyond 1979, as I see many issues lurking that could be at least better understood, if not resolved, if the lines of intergovernmental communications are strengthened.

In the field of sports and fitness, I would recommend that the ministry study and publish the comparative statistics on the fitness level of Ontarians. Even though the Alberta-based organization, Participaction, has done a great deal to raise the consciousness of Canadians about the fitness of their bodies, I feel your ministry could undertake research that would also help shock us into physical activity.

I was reading in the federal publication *Admittance Restricted: The Child as Citizen* in Canada that the fitness of Canadian children declines steadily after they start school so that the 12-year-old Canadian is as fit as the average 35-year-old Swede. So even though you might claim to have a fitness program in place, I would recommend that more impact is needed.

I will have some questions during the hearings on the physical fitness program which was introduced by Mr. Welch, to see how it is coming along, what progress has been made and the assessment that the ministry has made concerning it.

Finally, I would like to express some distress over the flagging fortunes of the Ontario lottery profits. I see from the December 1978 quarterly bulletin of Ontario Finances that profits are down. I know we have just received some estimates this morning, so I haven't had a chance to have a close look at them, but, as I say, the profits are down.

I wonder how Lottario, the newest of three Ontario government lotteries, is performing. Up until this morning, first-quarter figures for this lottery had been unavailable, perhaps because it is doing poorly. I think we must reassess the lotteries in terms of what success we can expect from them, what priorities they should serve, and how and by whom they are operated.

I have a number of questions pertaining to government lottery operations which I will submit later in the estimates.

I might also mention, while making my opening statement, dealing especially with Wintario in my riding, that I have had the total co-operation of the regional office in my area in filling out applications and seeing that they are processed.

[5:30]

My main bone of contention, especially with Wintario, has to be with the amount of time it takes to process these applications. It seems we can get people to fill out the

applications and the local offices to look after them and to send them into the ministry; but then we have complaints, such as the one that I had on Saturday evening about a library grant that was approved, I believe for Batawa of Frankford, Ontario, where they had to wait approximately 14 months before they got the cheque. It seems that it starts to go through the process but then meets the Wintario system. They wait for the minister to approve it; then it has to go to Treasury and they wait for Treasury to approve it; then it has to go back to the minister's office for the signing of the cheque.

As I say, there is something definitely wrong in the process when some of these things take six to 14 months to be approved. You are new in this but certainly have been made aware of some of these things. Somebody needs to be talked to in the ministry to see something is done to speed up that process.

I was also quite interested in your comments on TV Ontario. I would like to compliment you and your staff on much of the programming. There is definitely some improvement still needed. As you mentioned, there are some parts of the province where you hope to provide additional coverage. We will also look for a little bit of that in eastern Ontario; but I think the ministry can be proud of the job it is doing.

I was also interested in the comments you made on the native community and some of the things your ministry is doing there. Our members and I will have questions as we go along with the votes.

**Mr. Grande:** Mr. Chairman, let me begin by saying that the minister is new and the Liberal critic is new, but I have been here for three sets of estimates.

**Hon. Mr. Baetz:** Are you bragging or complaining?

**Mr. Grande:** I'm neither bragging or complaining. I think the minister must understand that there is someone who is doing an immense amount of work in following the things he is doing and how he is carrying on; there is someone who certainly hears from the arts community and arts groups in this province. Let me tell you that they really are not happy at all with you. As a matter of fact, they thought perhaps they would have a Minister of Culture and Recreation in this province who was going to be a full-time minister. What they are finding is a Minister of Culture and Recreation who—let me be kind to you—shoots first and asks questions later.

I want to deal with some specific areas, and in other areas to make very general comments which we will follow through with questions as we go along in the estimates.

I want to begin at the point of the events of last week. Let me say to you right off the bat that I am not at all shy in terms of politics entering the Ministry of Culture and Recreation. I am not concerned about the visibility of the ministry in the multicultural field. In the past seven or eight years, including the close to three years I have been here in this Legislature, I can point proudly to the fact that I have steered you in that direction. I have suggested many different activities and many different things that you should be doing, both in terms of the Ministry of Culture and Recreation and also the Ministry of Education.

You have acted on some; but you have acted gingerly, you have had to be pulled along screaming. However, you acted. For the good of whom is the big question. Whom did you act for? What are your motivations for acting? I guess I could never pin them down, but I could suspect this particular week has demonstrated to me your motivations and the reason why you are doing it.

I've said I welcome the injection of politics into the Ministry of Culture and Recreation, because, as you may very well know, the previous minister always said this is beyond politics; this is over and above, there are no disagreements here. However, the more you clearly stake your position the more clearly the people in the province are going to be looking at you, looking at this ministry, looking at this government and finding out whether this government is really serious and concerned about the direction, the multicultural direction and other directions within this ministry and the Ministry of Education.

I presented the motion in terms of getting Mr. Philippe LeBlanc to come before this committee. I think it is extremely important, as I've stated, that the Ministry of Culture and Recreation be able to prove the allegations.

I don't want to leave any doubts in anybody's mind of your motivations and your concerns. I'd like to think that your concerns are genuine. I've always believed that they should be genuine, especially in an area which is very sensitive indeed.

Race relations is a very sensitive area; multiculturalism is a very sensitive area. As you no doubt know, perhaps more than anybody else, I suppose, as one who has

been involved for almost all your life in the social development field, times of economic restraint, if you like to put it that way, are when the ugly side of some people within society emerges and there begin to develop schisms within society which are at times irreparable.

Therefore, I say to you, it is a delicate area. Move in, do the kinds of things you feel need to be done; but do them in a delicate, sensitive manner, otherwise you're going to be destroying—and I don't use that word lightly—the goodwill that exists in this province at the best of times and encouraging the reverse.

I'm going to get into that particular vote in depth as the estimates continue. I note we have decided to devote four hours to it. I don't foresee that all the four hours are going to be devoted in that particular area; perhaps one or two hours in the particular area of the charges and counter-charges that the minister was talking about, and in the other two hours we can discuss serious proposals, serious programs, which your ministry ought to be involved in and about which your ministry in the past three years has said, "We might get involved in that."

First of all, let me make a few comments about the ISA programs, the immigrant settlement agencies. As you know, the federal government pulled out. The federal government has said that the agencies that help the new immigrants would be funded only for two years; as if at the end of the two years the magical time has elapsed when people are going to be fully integrated and fully knowledgeable about the services the government has and the government offers, therefore at the end of the two years you are cut off, they are not going to provide the agencies with any money in order to continue the integration process.

The minister should know, Mr. Chairman, that although the integration process has a beginning, it certainly does not have an end, if we believe that people, as a group, or people as individuals, do it at their own speed and according to their particular needs.

However, what you have done, especially this year, is put the two-year criterion into effect in your ministry. You are not providing funds for more than two years. I understand you provided some funds last year, there was an exception, however beginning this year there is going to be a cutback in that program. Many of the agencies, immigrant settlement agencies such as the Portuguese free translation, the westend Y and the Italian immigrant service are just going to



close their doors, they are just not going to be around. Then you are going to have to provide those services, you are going to have to do it.

The agencies certainly are telling you what they need. They are saying to you there has to be core funding for those programs. There has to be a commitment to core funding, so that during the year they don't have to run around and try to find out where the dollar to provide the services is coming from, so that they can settle down to try to provide the best services they can to the people who require and need those services.

I also understand that the citizenship division and multicultural branch did go to cabinet to get some of the money, and the cabinet turned it down. So much for your sincere, genuine wish to help the newly-arrived immigrants.

In the Experience '79 program you are watering down, you are stretching to say the least, the amount of money you have at your disposal. All the other ministries in the government provide 100 per cent funding. You decide this year that you're going to provide 75 per cent funding. When those agencies rely 100 per cent upon government money, how on earth are they going to raise the 25 per cent in order to avail themselves of that grant the ministry offers for summer employment with those agencies? It's a deterrent, that's what it is. What you are doing is preventing the neediest sector of Metropolitan Toronto, or any other community that has newcomers, from even making an application because it cannot raise the 25 per cent; that's what you're doing. It's a deterrent fee, and perhaps it is scheduled to be just that.

Then you say, "If you cannot raise 25 per cent, we're not going to give you the 75 per cent. We're not going to be able to do anything about your application."

The Premier (Mr. Davis) has certainly stepped in on the Ministry of Culture and Recreation. Philippe LeBlanc gave the Saturday issue of the Toronto Star a copy of the letter the Premier sent to "Reuben,"—to "Dear Reuben"—in which he says, and let me quote just one part of the letter: "I venture to say that by concentrating our total efforts in one area and publicizing the location to the prospective clientele, we might soon regain the recognition lost in the past few years because of the wide proliferation of our multicultural efforts."

"We may soon gain the recognition lost over the past few years . . ." What kind of recognition is the Premier talking about?

I thought the ministry and the Premier were serious about multicultural policy. What kind of recognition?

If they are serious about the programs they have they will get the recognition, it's just a fact. Any government that reflects the needs of the people will enjoy the recognition. Obviously the Premier is concerned about something here, obviously the Premier seems to suggest that you have to do something above and beyond in order to gain back the recognition.

[5:45]

I just want to leave it at that point, because when Mr. Philippe LeBlanc is here. I want to explore that area and find out the Premier's motivation. I always understood—and I am really sincere about this—that even though the Premier himself, the Minister of Education, and the Minister of Culture and Recreation never understood what multiculturalism is—they have their own brand of it; that's fine—however, in the past three to four years they have been moving. They are doing some things.

I don't know what the motivation is, I don't know who is pushing them to do it; however they are doing it and that's fine by me. One of the reasons I was elected to this Legislature is perhaps for that particular purpose, to be doing a little bit of pushing, a little of prodding and nodding and saying to the ministries: "Look at the needs of 30 per cent of the people in this province and begin to address yourselves seriously to those needs"; and in the past three or four years, as I say, they are doing it gingerly.

Let me go on from there to the other area of the arts, because here I am glad that the new critic of culture and recreation from the Liberal Party did not say to you this year: "Cut, cut, cut. You don't need to have an increase in your ministry. You need to have cutbacks in your ministry."

I am talking about Mr. Kerrio. His very words were: "If any ministry in this government should be getting along without any increases, it would be this ministry." That's what he said. In a way you listened to what he had to say. I guess the Liberals have become the official opposition and you listen to the official opposition. So what you have done is you have cut the budgets of the cultural agencies, those agencies that you say are at arm's length with the government. You cut the amount of money, the increases to the Ontario Arts Council, to the Art Gallery of Ontario, to the museum, to every cultural agency as a matter of fact, to a 2.5 per cent increase this particular year.



**Mr. O'Neil:** Mr. Chairman, on a point of clarification, Mr. Kerrio is not here today and though we have heard some of Mr. Kerrio's views he is not here to defend what is being—

**Mr. Grande:** It is on the record.

**Mr. O'Neil:** —said of him. I am sure that when he was talking about cutting he wasn't referring to a lot of these organizations that you are talking about. He may have been referring to some of the money that he feels maybe shouldn't be going where it's going from Wintario. I don't like to leave the impression with the people here today or have it on record that he was for cutting back on many of these agencies, the arts council and other places that you are mentioning. That's just to clarify that point.

**Mr. Grande:** Just to clarify that point, I would invite you to go to the estimates of this ministry for the year 1977 and the year 1978, and you will find that what I have said might not be the exact words of Mr. Kerrio but certainly the intent of Mr. Kerrio's words are there.

You were saying that you want to keep at arm's length, and in a way I probably understand it if I accept your terms in which you want to keep the arm's length; but do you know what I fail to understand in your arm's length approach: I don't understand that the arm's length approach in terms of finances has to mean arm's length approach in terms of understanding. There's really very little understanding of the arts community and the arts groups in this province, very little understanding within your ministry. I am not trying to say that the other particular section of the ministry is not important, that is the recreation side of the ministry; it is most important, but it seems to me that you are heavy on the recreation side and very light, very light indeed, on the cultural side of your ministry.

The arts in the province of Ontario are not frills. We know what the federal government has done; it cut back in its budget, and the first thing it cut in its budget was the money or the funds that went to the cultural institutions. Somehow there is a feeling within the federal government and within this ministry that somehow the people of Ontario are not concerned about the arts; if the cutbacks come in the arts people will not pressure anyone in terms of increasing the funds that go to these agencies.

Let me tell you that while you look at the arts as some particular group who just use the creative side and the spiritual side and leave it at that, perhaps a lot of the people in the province of Ontario don't understand that, I don't know, perhaps they don't understand

that. Let me tell you that the arts community produces and creates a tremendous number of jobs, real jobs, for the people of the province. They are industries in their own right.

If you can provide money for the pulp and paper industries and for other industries, then treat the arts and the arts groups as cultural industry; treat the book publishing industry and the film industry in no other way than you would treat the pulp and paper industry in this province. They are just as important, just as essential and perhaps, I would say to you, in the long run, in terms of Canadian identity, in terms of our national unity, perhaps they are just a little bit more important, a little bit. I happen to be biased, you see; although I don't want to downplay the economic side, because the economic side has its particular ways of bringing about destruction in the goodwill of people.

I want to talk about the cultural industry which I refer to, the book publishing industry, and I want to talk in relation to that innovative program you set up last year, the Half-Back program. I would like to thank a man in your ministry, Mr. Robin Farr, for sending me what I asked for last year, and that is a copy of the results of that particular program. Throughout that it says—I read it I don't know how many times—the Half-Back program was successful. My feeling is that the Half-Back program wasn't even worth it. It might have been a tremendous package to raise the visibility of the ministry and to raise the visibility of Wintario, but in terms of its results it was pathetic.

Let me tell you some of the results that I read into that report. People who participated in the program amounted to nine per cent, and the penetration of the Wintario lottery tickets is 90 per cent in the province. So when you compare the 90 per cent of people who buy Wintario tickets and talk about the participation, you have got to admit it was a failure. You have got to admit that. People redeemed 1,200,000 tickets for a cost of \$600,000, and you had projected \$1,500,000 budgeted for that particular program. You had projected at least three times as many tickets would be redeemed.

For a program on which you paid out in rebates \$600,000 and had assumed that it would cost \$1,100,000, certainly the administration of that program was horrendous, was tremendous. So I don't understand where you are going to be saying to me that program was successful.

The relationship that was found is that people who read a lot just read a little bit more, but the overall objective of that program, if you recall, if you read the press

releases released by the former Minister of Culture and Recreation, (Mr. Welch), said that that particular program was to develop a readership in Canadian materials that was not there before. So on that count that Half-Back program was a failure.

Only 1,200,000 tickets redeemed out of 42,000,000 tickets sold during that three-month period, or three per cent of those tickets that were sold. That must give you concern that people were not really interested in rushing to their bookstores and redeeming their tickets.

Do you know what saved your program, the little bit of success that you had? One of the things that this ministry did not want to get involved in happened incidentally, and that is that there were a lot of school kids who got involved. Teachers involved those school kids in drives, and they brought losing Wintario lottery tickets to school and some of the libraries around Metropolitan Toronto and around this province are perhaps a little bit better stocked with Canadian-authored books. We all know the lack of Canadian-authored books in our own libraries in this province and in our own school libraries.

The reason I'm spending quite a bit of time on this particular innovative program of yours is because all you're concerned with is about the visibility of the program. You stated that a very high percentage of the people knew about the Half-Back program, so as far as you are concerned that visibility is all we need, so therefore the program was successful. As a matter of fact, it was so successful that you're even saying we're going to go into theatre with this, and we're going to go into buying records with this, and later on we're going to go into using the Wintario tickets so that people can go to sporting events.

In other words, it seems to me that once you take a look at the results which you have produced by the Half-Back program, and you go into that program in a bigger way, then it appears to me that you're not even conscious of taking your own results and doing a thorough evaluation. One of the things that I was looking forward to was to find out whether those people who bought Canadian-authored books with those tickets, returned to those bookstores to buy Canadian books after the program was over, because that's the real test, if you're able to attract people to go to the bookstore and then those people continue going to the bookstore.

I searched high and low in this report to find that basic information, but none of it

could be found. Why? As soon as the program ended those nine per cent of the people who went to bookstores, who go to bookstores anyhow and buy Canadian-authored books, just continued going but bought fewer books, that's all. You did not fulfil the condition or the major purpose of the program; that is, to attract new readership to the Canadian-authored books. You did not do that, and I would want to hear your comments. I guess we'll have to wait for another day, but I want to hear your comments in terms of this.

I want to say to you further that on your evaluation on the back page, where you ask people who should be funded in order to support the book publishing industry, they said to you exactly what the book publishing firms and those people involved in the book publishing business are saying to you, that is support book publishing and support the writers. As a matter of fact, the bookstores was the last that they said you should be supporting; not that they are saying you shouldn't support them, but the perception of the people in the province is that the only way to support and to help and to make viable the book publishing industry is to give to the book publishing industry and its writers, and to the writers of this province, some subsidy, some support.

I see that we have to get back to the Legislature for a vote, so I will continue tomorrow. I still have some material.

**Mr. Chairman:** Yes, would you wish to continue tomorrow Mr. Grande, or perhaps Wednesday? Mr. LeBlanc has agreed to appear before the committee tomorrow. I would assume the committee would want to deal with that matter first, and if there is time remaining after that, fine, you can carry on; if not, would it be suitable to complete your remarks on Wednesday; then the minister can respond to both critics and we can go into the groups after that. Would that be in order?

**Mr. Grande:** That would be fine, thank you.

**Mr. O'Neil:** Mr. Chairman, on a point of clarification: Since Mr. LeBlanc has agreed to appear before the committee tomorrow, in case we have some questions of some of the other people that he has made the allegations against, I wonder if it might be possible to have some of these people who were named—I believe there's a Bob Cook, a Whipple Steinkrauss, Joe Forster, and a Rocco Lofranco—also present at the committee hearings?

**Mr. Chairman:** What's the wish of the committee?

**Mr. Grande:** Mr. Chairman, I really don't want to prolong it. I think those particular people mentioned are people within the ministry and I understand that some of them are under contract, so I don't know to what extent the ministry would perceive it to be its function to talk about the role of those people who are under contract. However, I think the ministry should be able to prove the allegations, or one proves and one disproves, or whatever the situation is. I'm quite content in saying the ministry is responsible for one end of the deal and Mr. LeBlanc

from the other end. I would have no objections other than in terms of the time. We might go on into very continued long—

**Mr. Chairman:** My only concern would be that the whole matter would be turned into an inquiry and I don't think we want that. I think the whole purpose is to get the allegations of Mr. LeBlanc on the table to see what evidence he has to support them. Presumably the ministry will be countering those allegations, and at that point I think we can let it go at that. That would be my view. If there's material that emerges to indicate otherwise, we'll deal with it at that time.

The committee adjourned at 6:05 p.m.



CONTENTS

---

Monday, April 9, 1979

Opening statements: Mr. Baetz, Mr. O'Neil, Mr. Grande .....	S-7
Adjournment .....	S-23

SPEAKERS IN THIS ISSUE

---

- Baetz, Hon. R. C.; Minister of Culture and Recreation (Ottawa West PC)
- Blundy, P. (Sarnia L)
- Breaugh, M. (Oshawa NDP)
- Campbell, M. (St. George L)
- Conway, S. (Renfrew North L)
- Gaunt, M.; Chairman (Huron-Bruce L)
- Grande, A. (Oakwood NDP)
- Kennedy, R. D. (Mississauga South PC)
- Lawlor, P. D. (Lakeshore NDP)
- McClellan, R. (Bellwoods NDP)
- O'Neil, H. (Quinte L)
- Rowe, R. D. (Northumberland PC)
- Sweeney, J. (Kitchener-Wilmot L)

2  
7

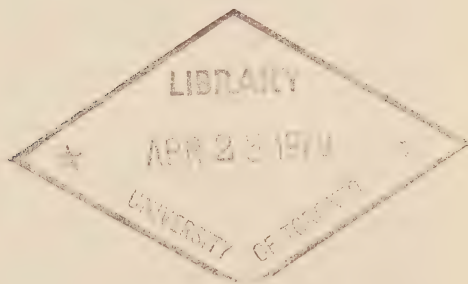


# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Estimates, Ministry of Culture and Recreation



**Third Session, 31st Parliament**

Tuesday, April 10, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

TUESDAY, APRIL 10, 1979

The committee met at 3:27 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

**Mr. Chairman:** I see a quorum. We have Mr. LeBlanc here today as a witness but, before we deal with that matter, there is a carryover matter from yesterday which I think we should get out of the way first; that refers to Mr. Lawlor's motion.

**Mr. Conway:** In that connection, because we want to deal with this as quickly as possible, as you know from yesterday we did have an opportunity to look at Mr. Lawlor's motion. We had a discussion, my colleagues and I, and we find in general that the motion, certainly in its principal aspects, can be supported and accepted.

We would, however, offer the following amendment to Mr. Lawlor's motion, and I shall move that amendment now.

**Mr. Kennedy:** Mr. Chairman, some of us weren't here yesterday.

**Mr. Chairman:** Do you want me to read the original motion, Mr. Kennedy?

**Mr. Kennedy:** Yes. If you do that, we can then follow the amendment.

**Mr. Chairman:** Mr. Lawlor moved:

"Pursuant to the referral of the annual report of the Ministry of Health:

"Be it resolved that: consideration of this report be concentrated on the decision to close Lakeshore Psychiatric Hospital; the committee be provided with legal counsel and any other staff deemed necessary; the committee hear witnesses under oath; the proceedings be transcribed and recorded in the same format as the daily Hansard; and the committee present a report or reports to the Legislature with its own recommendations regarding Lakeshore Psychiatric Hospital."

**Mr. Conway:** I would move the following amendment so that we can discuss both the amendment and the motion.

I would amend Mr. Lawlor's motion accordingly to read:

"Pursuant to the referral of the annual report of the Ministry of Health:

"Be it resolved: that this report be considered immediately; that consideration of this report be concentrated on the decision to

close Lakeshore Psychiatric Hospital and to close active treatment beds in other public hospitals in Ontario without providing adequate alternative care; that the proceedings be transcribed and recorded in the same format as the daily Hansard; that the committee present a report or reports to the Legislature in this regard; and that, without restricting the time spent by the committee on this special reference, not more than five hours shall be deducted from the time allocated to the examination of Health estimates."

I think everyone has a copy.

**Clerk of the Committee:** I haven't got one.

**Mr. Chairman:** Could we have a copy?

**Mr. Breaugh:** If I could speak to the amendment, I believe there may be some small problems caused by the amendments, but we are certainly prepared to accept any amendments that may be necessary to get the initial motion under way and we will be happy to support them.

It would be my suggestion to the committee that you might care to strike a steering committee to set up appointments and what not, and that probably would consist of Mr. Lawlor, Mr. Conway and one other volunteer—maybe Mr. Kennedy might like to serve in that capacity. They would help the chairman set up the scheduling of hearings.

**Mr. Chairman:** An excellent idea, Mr. Breaugh.

[3:30]

**Mr. Lawlor:** I am ecstatic over the amendment; it's one of the peak experiences of my life.

I agree with the steering committee proposal. One of the jobs—and I think we should have this enunciated—of the steering committee should be to see that ads are placed in the press. I'm going to make the proposal, and I want you to know it now, that such an add be placed, not in the regular Toronto newspaper—my own feeling is it is not necessary—but in the local papers in Mr. Kennedy's demesne and in Etobicoke, and in places called Peel, to keep the cost of this thing down. As far as I know, we will not be requiring or asking for counsel or any other help in this matter.



**Mr. Chairman:** We had an advertising budget approved last night, Mr. Lawlor; so we do have—

**Mr. Lawlor:** Forty-eight dollars?

**Mr. Chairman:** No. As a committee, we have a total budget of more than \$48,000, of which \$10,000 is set aside for advertising purposes.

**Mr. Lawlor:** Wow! We can place it in the Milwaukee Herald.

**Mr. Conway:** Mr. Chairman, I want to speak to Mr. Breaugh's point; I think it's an excellent one. The Liberal caucus is most supportive of the steering committee concept, because clearly the double-barrelled reference here is one that we will have to be guided by, particularly in the light of time constraints. I think we all understand that; it's not our intention to be insensitive to that. I would be very happy to accept Mr. Breaugh's concept of a steering committee and would support it happily.

**Mr. Gregory:** Mr. Chairman, certainly we don't find the motion or the amendment objectionable, but I'm very curious as to why we would depart from the normal practice of committees that, when you do deal with reports during estimates, 50 per cent of the time will not be deducted from the estimates time. That's the normal practice of committees.

**Mr. Lawlor:** You're not questioning House leaders, are you? Is nothing sacrosanct around here?

**Mr. Gregory:** Well, your party has proven that.

**Mr. Chairman:** could you explain to me why?

**Mr. Chairman:** Mr. Gregory, I should tell you, there was some discussion yesterday, revolving around the matter of deducting estimates time. It was the general consensus of the committee that the matter related to the Lakeshore Psychiatric Hospital—and now, it turns out, any other matters related to hospitals and hospital bed cuts—should not be deducted from estimates time on the original formula basis; that is, that 50 per cent of the time used be deducted from the total allocation, in this case from the Ministry of Health. That matter was pursued with the House leaders, and I am of the understanding that it was agreed to change that.

In other words, the consensus of the committee was to change it and, while I stand to be corrected, I believe the House leaders have concurred in that.

**Mr. Kennedy:** Mr. Chairman, could you explain the total time? There is 20 hours allo-

cated to Health; this suggests five hours be deducted from that, as I understand it, leaving 15 hours. But what is the total number of hours that would be taken up in dealing with this report?

**Mr. Chairman:** The thrust of Mr. Conway's amendment, as I read it, is that it would be open-ended. If at some point in time, the committee was starting to feed on itself, if I may use that term, then obviously we as a committee could determine to cut it off. But at the moment, with respect to the amendment that's on the table, it's open-ended.

**Mr. Gregory:** Mr. Chairman, I seem to have lost the floor here; I hadn't quite finished—

**Mr. Chairman:** I'm sorry, Mr. Gregory.

**Mr. Gregory:** I'm given to understand that there has really been no agreement with the House leaders on this particular formula. I'm informed that there was some desire on the part of at least the government party to continue with the present formula of half the time. I want the why of it explained to me. You tell me there was a consensus among the committee members that this should be departed from, and that the House leaders had agreed to this. I understand that's not the case; the House leaders have not agreed to it.

I'd like to see a consensus of the committee again to determine if it should be departed from. That is my suggestion—that 50 per cent of the time would be more equitable, as opposed to five hours.

**Mr. Chairman:** If I'm incorrect in assuming that there was a consensus among the House leaders, I think I can accurately state that there was a consensus among two of the House leaders. Perhaps there was a disagreement insofar as the government House leader was concerned. I'm not aware of it.

**Hon. Mr. Welch:** I think it's unreasonable to send this back to the House leaders. The House leaders had a discussion about it yesterday and really decided that the matter was better left with the committee. I think the committee is quite at liberty to make whatever decision it likes. But please don't lay the blame on the House leaders with respect to the time.

**Mr. Chairman:** I wasn't laying the blame—

**Hon. Mr. Welch:** The House leaders agreed yesterday, in an informal way which by no means committed anyone to anything, that the practice had been, when a ministry was before the committee, for the discussion of the report time be followed by the estimates.

It was reasonable to presume that, since the subject matter of the report referral would no doubt be in the estimates as well, that there be some reduction in the estimates time.

The practice had built up by agreement, to 50 per cent. The question I heard Mr. Gregory ask was: why wasn't that followed here? The reason it wasn't followed here, I heard the chairman say, was because the House leaders agreed otherwise. That's not a reasonable assumption to make. I think it's for the committee to decide if the time allowance is to be five, six, seven, 100 hours. But, in fact, we had noted, in our informal discussions, that the time period usually had been 50 per cent.

You can surely decide otherwise. After all, that's completely within the purview of the committee to make that decision. But I'd rather it be the committee's decision than appear to reflect the House leaders' agreement. There is no such agreement binding on this committee.

**Mr. McClellan:** Let's take the vote.

**Mr. Chairman:** Mr. Welch, I apologize if I conveyed the impression that I was putting the blame on the House leaders. I didn't intend that at all. I was just under the impression that the House leaders had discussed the matter and that there was no objection to departing from the formula.

**Mr. Lawlor:** So was I, Mr. Chairman.

**Mr. Chairman:** If that isn't the case—Mr. Lawlor tells me that was his impression—then fair enough. There's no problem. We can decide the matter here in committee and that's even better.

**Mr. Conway:** Why don't we put the question?

**Mr. Chairman:** Are you ready for the question? With respect to Mr. Gregory's point, should we clear that first?

**Mr. Breaugh:** I just want to point out for the committee's consideration that I think most of us are tempted to talk to our House leaders and get their viewpoints. That was done, in the case of our caucus, by Mr. McClellan, Mr. Lawlor, and myself. We had a very thorough discussion about that.

I think it obvious now that you have a motion before you which clearly will give the committee an opportunity to decide its own business. I would suggest that rather than discuss this for nine hours, why don't we vote on the amendment and the main motion that's before us? Then the committee will have decided how to order its business. It's within the committee's scope to do that. I don't think we are interested in laying the blame at the

House leaders' doorstep. They're already to blame for so many things around here.

**Mr. Gregory:** Mr. Chairman, would it be proper to offer an amendment to the amendment that the previous schedule of 50 per cent be adhered to?

**Mr. Chairman:** It's in order, Mr. Gregory. I had hoped that we could deal with this matter quickly because I don't want to take too much time. As I indicated initially, Mr. LeBlanc is here and this afternoon was set aside for him. But I'm quite prepared, if you want to do that, to make a motion to amend the amendment to the motion.

**Mr. Gregory:** Really what I am trying to do is to adhere to the previous format the committees have used. I'm perfectly in agreement with the motion and the amendment, with the exception of the time allotment. I'm suggesting that the regular schedule be adhered to, however you want that worded.

**Mr. Chairman:** I don't think we need that written out. Could the committee vote on the amendment to the amendment and then we'll go to the amendment to the motion and then to the motion if need be. Is that agreed?

**Mr. Kennedy:** Mr. Chairman, first could I get some clarification? If it's 50 per cent and there's five hours from estimates, does this mean that the report will be 10 hours of discussion? Is that what we're saying?

**Mr. Chairman:** As I understand what Mr. Gregory is saying, if the total inquiry consumed 14 hours, then seven hours would be deducted from the 20. Isn't that what you're saying?

**Mr. Gregory:** Yes.

**Mr. Kennedy:** Yes, all right.

**Mr. Chairman:** Are you ready for the question? The amendment to the amendment is being put first.

Motion negatived.

**Mr. Chairman:** Now the amendment to the motion.

Motion agreed to.

**Mr. Lawlor:** I have another motion. I know you want to get on with this thing and therefore I'm sure you'll do this with great expedition and there will be no controversy whatsoever.

**Mr. Chairman:** Mr. Lawlor moves that at the next sitting of the House this committee present an interim report and recommend the adoption of the following motion:

"Whereas this committee will be reviewing the decision to close Lakeshore Psychiatric Hospital by September 1, 1979; and



whereas the current transfer of patients and closure of the special observation unit seriously impair the hospital's ability to deliver psychiatric services to the local community; therefore, all patient transfers should cease forthwith and the special observation unit should be reconstituted immediately at the hospital pending the final report of this committee's deliberations."

**Mr. Lawlor:** I have numerous copies of this motion, Mr. Chairman. If I may speak to it for a moment.

This places everything in suspension pending a determination by this committee as to what it thinks, having heard the evidence and having been given a fair and objective assessment and hearing presentations from the public for the first time.

The action in this instance was taken unilaterally and without consultation with the minister—visited from above, Jehovah fashion. Since this is an open-minded committee and willing to listen to these matters and since blunders may be made, and since the ministry is in the process of evacuating the hospital at the present time, and since our deliberations may prove to be inefficacious, I'm asking for a brief period of time, since this thing will come on in a couple of weeks, in which nothing further be done.

The special observation unit is a unit in the hospital which assesses patients, allocates them to wards. I don't know how they can operate without them. My information is that it's disruptive in the extreme and the action was performed while the minister was on vacation.

I'm asking you to accept this motion.

**Mr. Conway:** Mr. Chairman, I'd ask for a briefer time even yet in respect to Mr. Lawlor's motion which unhappily I do not yet have a copy of. I'm wondering if the member would be so kind—given the gravity of certain implications of this motion—as to accept a motion to table this until tomorrow. I would like some time to discuss it with my colleagues. I would serve some notice that in the absence of at least a few hours to do that I would have no choice but to recommend their voting against it. So if you're prepared to table it until we meet again tomorrow then I would appreciate that, otherwise I would have a difficult time considering it.

**Mr. Lawlor:** Oh, Conway, I'd do practically anything for you.

**Mr. Conway:** Thank you very much.

**Mr. Lawlor:** But I would also say that indecisiveness is the bane of parliamentary

life and we must grapple with these horns of dilemmas even if they stick in your groin. On this particular occasion, as yesterday, okay, we'll give you 24 more hours. May we do that, Mr. Chairman?

[3:45]

**Mr. Chairman:** Tomorrow afternoon? Yes.

**Mr. Conway:** That's fine and very agreeable of you, Mr. Lawlor. We will meet again tomorrow at one o'clock and decide the fate of this motion.

**Mr. Chairman:** Is it agreed that Mr. Lawlor's motion be tabled until tomorrow?

Agreed to.

**Mr. Lawlor:** It's one way of getting around it, isn't it?

**Mr. Chairman:** It certainly is.

**Mr. Breaugh:** Accepting that Mr. Lawlor's amendment has been tabled, could we now have the vote on the main motion? That's the advantage of having someone here from the procedural affairs committee.

**Mr. Chairman:** We shall vote on the main motion as requested by Mr. Breaugh.

**Mr. Kennedy:** How can we do that when it is tabled?

**Mr. Conway:** The motion as amended.

**Mr. Kennedy:** Let's defer them both.

**Mr. Chairman:** The consensus of the committee was to vote for the amendment to the motion. Presuming that, I gather the members will act accordingly. In any event, Mr. Breaugh wants a recorded vote on the motion, as amended.

Motion agreed to.

**Mr. Chairman:** Mr. Lawlor's other motion will be dealt with tomorrow.

## ESTIMATES, MINISTRY OF CULTURE AND RECREATION (continued)

On vote 3004, citizenship and multicultural support program; item 1, citizenship development:

**Mr. Chairman:** Mr. LeBlanc please. Is it the wish of the committee that the Chair administer the oath to Mr. LeBlanc?

**Mr. Grande:** Yes, I think it would be preferable to do that.

**Mr. Chairman:** Would you be good enough, Mr. LeBlanc, to take a chair at the end of the table?

**Mr. Gregory:** I am not wishing to cause trouble. As you know, I am not prone to do that. If there is a substitution at the begin-

ning of a meeting, does that substitution not carry through the whole meeting?

**Mr. Chairman:** Yes, it does. That is my understanding,

Philippe LeBlanc sworn.

**Mr. Chairman:** Do you have a statement, Mr. LeBlanc, or would you prefer that the committee members go right into the questioning? Does the minister have a statement?

**Hon. Mr. Baetz:** I have a statement but I would prefer to wait until Mr. LeBlanc makes his statement, if he has one.

**Mr. Blundy:** For the sake of all the members of the committee, I would suggest that Mr. LeBlanc be asked to read his letter of resignation so we will all know exactly what he said in the letter.

**Mr. Chairman:** Would that be agreeable, Mr. LeBlanc? Could you do that?

**Mr. LeBlanc:** Mr. Chairman, I had prepared a statement which summarizes the matter. I could leave a copy of my letter of resignation with the Chair. It could be copied and distributed.

**Mr. Chairman:** I think that would be satisfactory.

**Mr. LeBlanc:** I am here today as an unemployed private citizen and also, I gather in my capacity as the former director of the multicultural development branch of the Ministry of Culture and Recreation.

I welcome this opportunity to assist the committee in any way possible and also to defend the concerns which I raised in my letter of resignation, dated April 1, 1979, to Mr. Baetz. At the outset, allow me to dispel at least one accusation that was made against me personally. I would like to take this opportunity to deal with it.

I would like to say that I have never been involved in partisan politics. I am not a member of the Liberal Party or of any other political party. In fact, anyone who knows me is well aware of my stand on the question of civil servants' involvement in politics. I have been called, on that point, a purist. I personally do not believe that a civil servant should be involved in any way, as a civil servant, in partisan politics. That has always been my position, and I have made it known on many occasions to my own staff and to other people who have questioned me on that point.

My view is that a civil servant is someone who has been given a public trust and a mandated responsibility to carry out policies and programs duly approved through the legislative process. For example, I consider the ministers for whom I have worked

as ministers of the crown who were given certain public responsibility, and I did not view them as members of a political party. Therefore, anyone who knows me well was certainly shocked, as I was, to read in the *Globe and Mail* the statement that I was acting in a partisan political way in this whole affair. It really is contrary to my convictions.

The major concern which I raised in my letter of resignation to Mr. Baetz is that public trust was broken when our multicultural programs were given a new orientation to achieve what are, in my view, partisan political aims.

At the beginning of my tenure as director in 1976, I was instrumental in developing programs that were geared to the promotion of multiculturalism and the promotion of intercultural and racial harmony in the province. They were designed to meet the needs of visible minorities and other ethnocultural communities, consistent with the first two elements of the province's multicultural policy, which our branch drafted, namely: (1) the equality of all residents of Ontario, and (2) equality of access to all government services, regardless of background, and full participation in Ontario's society. That policy was announced in May 1977.

Our multicultural programs had, therefore, been developed within the ministry and had been approved by the ministry and by Management Board of Cabinet, with whom we had to file management-by-results forms outlining our activities. The direction of the multicultural development branch, its priorities and its programs were, therefore, well known to the minister, to the deputy minister and even to members of Management Board of Cabinet.

With the arrival of the new deputy minister, Dr. Douglas Wright, the change in orientation in our programs was dramatic. Upon my return to the ministry—I was absent for one month, from February 5 to March 5, because of a skiing accident—I was brought up to date on the new direction. Dr. Wright arrived in the ministry on February 5. It was made clear to me that the new direction was political and partisan, and that we would have to live with it.

The shift happened because Dr. Wright, I was told, was given a mandate to make multiculturalism a priority in the ministry and especially by ensuring that the government's profile be heightened. Program activities were to be developed that would give the government political visibility.

In a letter to Mr. Baetz, dated February 22, 1979, the Premier (Mr. Davis) stated: "I know of the initiatives that you are plan-



ning in Culture and Recreation, and as part of this I feel we might benefit from giving our total government operation a much higher profile."

My contention is that the Premier's office is involved in this new direction through Mr. Bob Cook, who acts as chairman of the intergovernmental committee on multiculturalism. His influence under Dr. Wright became an important factor in determining the direction of our programs. As chairman of that committee, which I mentioned a moment ago, since 1977 Mr. Cook was primarily preoccupied with the political side of multiculturalism, while the committee members were concerned as professional civil servants with the program side. I can speak with some authority since I was our ministry's representative on that committee.

Mr. Cook expressed his concern to me a number of times over the fact that the federal program was receiving much greater publicity and that we should strive to do the same. For two years, with the support of senior officials in our ministry, I successfully prevented Mr. Cook from interfering what I call politically in our programs. As you know, Mr. Cook was appointed chairman of the committee by Honourable Mrs. Birch and, therefore, reported to her through Dr. Wright for the past two years.

Since February 5 of this year, the ministry has been clearing new program initiatives with the Premier's office through Mr. Cook. The new direction which I describe in my letter of resignation is one which I can only qualify as partisan and political. In my view, it was developed to gain the support of the ethnic cultural community politically through publicity and other high visibility efforts. It was inevitable with the new direction that programs designed to meet the needs of immigrants of ethnic culture minority groups would suffer as funds and human resources would be diverted to meet the political demands that were being imposed upon us. It was in that context that I stated that, in my view, it was a totally unacceptable and corrupt practice and that in my opinion it represented an inappropriate use of government funds and a misuse of civil servants.

In conclusion, as I see it, since February 5 of this year partisan direction influencing our programs came from the Premier's office, and civil servants were asked to develop, rationalize and become involved in activities that would be politically beneficial. Funds and other resources were to be used primarily to give the government a higher profile, rather than alleviating the racial and

other tensions for which we had been given resources in the first place. It was, therefore, on a question of principle that I submitted my resignation on April 1.

Thank you very much, Mr. Chairman.

**Mr. Chairman:** Thank you, Mr. LeBlanc. Mr. O'Neil.

**Mr. O'Neil:** Thank you very much, Mr. Chairman.

**Mr. Chairman:** Mr. Minister, would you care to respond at this point and then Mr. O'Neil?

**Hon. Mr. Baetz:** Mr. Chairman and members of the committee, as I have indicated on previous occasions, I am indeed very sorry personally that we have to go through this discussion indirectly through the committee with Mr. LeBlanc. I would very much have hoped and I would have welcomed having Mr. LeBlanc talk to me about the deep concerns he has expressed in his letter of resignation. I would have hoped that he would have conveyed those concerns to me, either directly or via the civil service staff.

I can assure him, and I think he knows me well enough to know it, that had he expressed some concerns, I would have been prepared certainly to discuss them, because I think my own record before going into the active political arena is also one which provides some indication at least that I too have some concern about undue political intervention in areas as highly sensitive as multiculturalism and interracial relationships.

Really, I am very sorry that Mr. LeBlanc did not choose to express his concerns to me before his letter of resignation. In fact, the first I heard of the letter of resignation was through a Globe and Mail reporter calling me about it.

[4:00]

The other thing that is of further surprise and regret is that Mr. LeBlanc chose not to discuss this whole matter with the director of his own division, Mr. Robert McPhee. I do not for one minute quarrel with the statements that have been made, that Mr. LeBlanc has an excellent record—I think someone said impeccable—but equally I think it must be stated that the record of his supervisor, the director of the division, Mr. Robert McPhee, is equally impeccable.

Mr. McPhee has had a long record of distinguished service, first as an ordained minister in the United Church of Canada, later on with the federal government working for Mr. Andras in native affairs, followed by a very excellent term with the Ontario Human



Rights Commission, and has now done a yeoman's job in our ministry.

I cannot help but believe that Mr. McPhee would have had an open mind and would have been receptive to any points of concern that Mr. LeBlanc had on a subject that is as close to Mr. McPhee's heart as this one. Again, Mr. Chairman, I am sorry that we have to debate this issue in this kind of forum.

In the letter of resignation, as Mr. LeBlanc has again indicated today, there were rather general points of concern, but he elaborated or illustrated his concerns through four rather specific incidents that took place.

The first was the allegation that the relocation of Ontario Welcome House was politically motivated and was initiated largely by initiatives which emanated from the Premier's office, whether directly from the Premier in his letter to me or through Mr. Bob Cook.

I would like to say for the record that the initiative to move Ontario Welcome House to a far more central location, a more readily accessible location, did not emanate from the Premier's office. In fact, I will file here for your records a letter dated as early as September 1976, written by the supervisor, reception services, with the full knowledge of the former citizenship branch director, Charles Beer, in which he recommended to the director, administrative services branch, that a new and more central location be found for Welcome House. That was back in September 1976. I shall pass that around here, and I shall simply read one part of it:

"At the present time the Welcome House, the citizenship branch ESL school and related services occupy approximately 24,000 square feet on the entire first and third floors at 8 York Street.

"Alternate accommodation should ideally have a minimum of 12,000 square feet on the main floor of a readily accessible three- or four-storey building situated within the area of Dundas, Jarvis, Bloor and Bathurst.

"An older building, attractively painted and in good repair, would serve the purpose very well.

"The Ontario government needs not only to be concerned about resident and arriving immigrants but needs to show that concern in a visible form open to all so that 'access to services' and appropriate referrals can be made for the benefit of all."

That is a letter dated September 20, 1976, and came out of our own staff. This letter was signed by M. R. Mackenzie, directed to Mr. Halstead, director of administrative services, Ministry of Culture and Recreation. That letter was followed in October 1976 with a

request from the director of administrative services of my ministry to the Ministry of Government Services for a more central location specifying, and I quote: "The space should be located between Dundas, Jarvis, Bloor and Bathurst." I will file that letter, Mr. Chairman.

I will again read from it here. It says: "Given all the problems and almost impossible task of getting structural alterations made at 8 York Street, we suggest that a new and more central location be found for the Ontario Welcome House, a service widely known for its multilingual access to service capabilities. The space requirements for Ontario Welcome House would be approximately 24,000 square feet"—and so forth—"but, ideally, the space should be located somewhere between Dundas, Jarvis, Bloor and Bathurst Streets."

As you can see, my ministry has been actively pursuing this idea for over two and a half years and, as I say, Mr. Chairman, it did not emanate and originate from the Premier's office, either directed by the Premier, Mr. Cook or anybody else.

I think it's unfortunate if Mr. LeBlanc had concerns about this, at no time did he voice or document any objections to the relocation of Ontario Welcome House. In fact, on March 26, a week before he resigned, he sent a memo to his executive director with some constructive comments and suggestions about Ontario Welcome House. If you wish to have that letter I can also table it. So, Mr. Chairman, I'm tabling those three pieces of correspondence for the committee's information.

The second specific incident that Mr. LeBlanc has referred to in his letter of resignation, and again today, alleges an improper influence on the ministry multicultural policy development by the Premier's office through Mr. Robert Cook. The creation of an interministerial committee on multiculturalism was recommended and the multicultural policy papers submitted to cabinet by the ministry in November 1976 and confirmed in the Premier's speech of May 4, 1977, when the government's multicultural policy was announced.

The committee's chairman, at that time, was Mr. Robert Cook, Office of the Premier, as we've heard. Membership consisted of representatives from the following ministries: Community and Social Services; Attorney General; Colleges and Universities; Labour; Health; Education; Correctional Services; Solicitor General; Culture and Recreation; and Management Board and the secretary was Jill Robinson from the Ontario Human Rights Commission. My ministry's representa-

tive was Mr. Philippe LeBlanc, director of our multicultural development branch.

The purpose of the committee, in the words of the Premier, was to give government "a totally new and effective vehicle by which all government policies related to multiculturalism can be co-ordinated and accentuated in the best way possible."

I have here, Mr. Chairman, and ladies and gentlemen, a record of the meetings of that committee of October 25, 1977; December 2, 1977; February 6, 1978; March 21, 1978; May 4, 1978, and July 14, 1978. I think what's indicated here is there was certainly nothing unusual about this committee. It was not hastily thrown together. It has been operating, maybe some people would say not as effectively as it might have, but it certainly has been operating for a long time and quite open and above board.

The third point Mr. LeBlanc made in his letter of resignation was he alleges that Mr. Joe Forster, an information officer of the ministry, "convinced a Metro Portuguese group to arrange a dinner," and that he, Joe Forster, influenced the guest list for this dinner.

We have, since then, heard on a number of occasions that, in fact, there were only members of my political party present at that meeting. I have from the very beginning denied that and the president of the Portuguese Club has denied it verbally.

Today, at noon, I received this letter from the president of the First Canadian Portuguese Club of Toronto, a Mr. Saragoca, who said:

"My executive and I are most alarmed at reports that have suggested we have been directed as to who should be invited by the club executive to our recent dinner on March 18.

"This is simply not true. We met with Mr. Forster to seek his guidance during the planning of the dinner itself. Mr. Forster suggested to us at that time that it would be much better to have an informal, rather than a formal affair. When we asked him for advice regarding invitations, he stated it was entirely our own privilege.

"Printed reports suggest that New Democratic members of the Ontario Legislature were not invited. Again this is simply not true. Mr. Ross McClellan, New Democrat MPP for this riding, was invited. Also invited were the following people:

"Miss Aileen Nicholson, MP; Mr. Larry Grossman, MPP; Mr. Art Eggleton, alderman; Mr. Tony O'Donohue, alderman; Mr. Allan Grossman, former MPP.

"I trust this letter will help clear up the situation. Mr. Forster has been a longtime friend of the club and continues to enjoy our greatest respect.

"Yours truly, M. Saragoca, President."

I file that.

Finally, Mr. LeBlanc alleges that the Premier's office influenced the decision regarding the selection of a public relations firm for my ministry's race relations campaign.

The ministry requested proposals for the campaign from five different companies. Although a committee within the ministry did recommend that ACI, which stands for Analytical Communications Incorporated, be awarded the contract, this recommendation was not accepted by senior officials of the party or by myself. I can tell the committee, I did not have the slightest direction from the Premier's office or anyone even closely associated with the Premier's office in my decision on the proposal that was made to develop this PR campaign.

A decision was made to carry out this campaign utilizing existing creative material and inhouse staff resources. I can assure members of the committee that this is the reason we did not award a contract to ACI or, indeed, to any other company; we did it inhouse.

I have here in front of me, and I have prepared copies of, the proposal by ACI to carry through this public relations program on race relations. We had \$60,000 in our budget and had less than eight weeks in which to implement that program and to carry it forward. When I read back, and it must have been about January 27 when I got this proposal, I can assure you I decided on this basis that we could not accept this proposal at all.

I will pass it around. I am sure everyone around the table would have reached the same conclusion. They pointed out, for instance—and, as I said, we had \$60,000 to spend on billboards, on radio spots, on pamphlets and everything else—"We estimate the fees and expenditures would be equal"—for their staff only as the middle agency—"to \$30,000. Fees would be higher than normal in ratio to expenditures as much of the spade work for phases one and two can be done under this program."

Gentlemen, I am in no way denigrating the work of this agency at all. I am simply saying that for our very limited program to be carried out in less than eight weeks, this proposal was far, far too elaborate. That is why I said we must do it inhouse; we would save the taxpayers' money, and that is what



we have done. We have not hired another agency. We have gone ahead. The billboards are up in Toronto and other cities throughout Ontario, the spot ads have been produced, Joe Forster helped to produce them and the program is under way at a much lower cost. There was certainly no undue interference from the Premier's office on that or anything else.

I think those are really four incidents that I have, with the help of my staff, tried to document for your consideration. I have tried to underline that there is not this kind of undue political interference or political orientation in the multicultural program that Mr. LeBlanc has suggested, or that led to his resignation.

[4:15]

As I said, I am really sorry that Mr. LeBlanc chose to go to the press, to share with the Toronto Star, I believe it was, the letter that the Premier had directed to me. I didn't think it was a political document. If it had been a political document I wouldn't have had it circulated through my department. I guess it got on to Mr. LeBlanc's desk, but I am disappointed that he chose while he was still under oath to take that letter and share it with the media. However, that was his choice and that can't be helped. So it is really more in a mood of regret than anger that I present you this report, Mr. Chairman.

**Mr. Chairman:** Thank you, Mr. Minister. You have a point of clarification, Mr. Grande?

**Mr. Grande:** Point of information, Mr. Chairman: is the minister tabling all those reports which he was reading from?

**Hon. Mr. Baetz:** With pleasure.

**Mr. Grande:** I would appreciate having copies.

**Mr. McClellan:** That includes Mr. Cook's report to cabinet, I understand.

**Hon. Mr. Baetz:** That includes Mr. Cook's report to cabinet?

**Mr. McClellan:** With respect to the second item—

**Hon. Mr. Baetz:** I have referred here—

**Mr. McClellan:** —you referred to a report that Mr. Cook had prepared, I think prior to the—unless I misunderstood you—

**Hon. Mr. Baetz:** I can table here a synopsis of the work of the interministerial committee on multiculturalism and when it met and who is its chairman and what they are doing.

**Mr. McClellan:** Did I misunderstand that you made reference to a specific report prepared by Mr. Cook himself leading up to the announcement of—

**Hon. Mr. Baetz:** Yes, I now know what you are after. I referred to a report which recommended the creation of that interministerial committee.

**Mr. McClellan:** You referred to a report written by Mr. Cook, I believe. Am I wrong?

**Hon. Mr. Baetz:** No, not by Mr. Cook.

**Mr. McClellan:** I will look at the transcript.

**Mr. Chairman:** The documents are tabled, Mr. Grande, as exhibits, if the committee members wish them.

**Mr. Grande:** However, Mr. Chairman, the minister does have another report which I believe—and I guess the record will show—he referred to and he is not tabling.

Anyway, the motion that was presented yesterday, and which, this committee approved, is in terms of having material and other things from the ministry regarding this particular matter. I would suggest that before we get on with this vote there are going to be certain materials which I am going to be asking that the ministry table with the committee.

**Mr. O'Neil:** Mr. Chairman, since Mr. LeBlanc started off today and is here at the request of the committee, and since the minister has had a chance to make a statement, there may be some points he may like to clarify at the end of the sitting and maybe we should give him the chance. Hopefully some answers will come out to questions we or the other members have.

**Mr. Chairman:** I would presume so, Mr. O'Neil. If not, Mr. LeBlanc is free at any time to interject or clarify.

**Mr. O'Neil:** Okay, I have some questions.

**Mr. Kennedy:** Mr. Chairman, could we get a copy of Mr. LeBlanc's letter of resignation? The committee members don't have one and—

**Mr. Chairman:** I don't have one either, Mr. Kennedy, but we can get that for you.

**Mr. Kennedy:** Could we get it as quickly as possible?

**Hon. Mr. Baetz:** I have the original copy right here; you can photostat it if you like.

**Mr. Chairman:** The clerk can photostat copies for the committee members.

**Mr. O'Neil:** Are we ready, Mr. Chairman?

**Mr. Chairman:** I think we are ready, Mr. O'Neil.

**Mr. O'Neil:** Mr. LeBlanc, some accusations have been made, or possibly questions have



arisen, as to why you did not discuss with the ministry or with Mr. McPhee these matters that you put in the letter of resignation. I wonder if I could have your comments, first of all, on that.

**Mr. LeBlanc:** Mr. Chairman, in answer to the question, I want to say that this was a personal decision. As I said in my opening statement, I was away for a period of one month. I had been replaced by an acting director and when I returned to the ministry a number of things had already taken place. I felt that at that time I had to make a few decisions. The first decision I made was to resign on a question of principle. The second one was exactly how far I wanted to carry that principle.

I did not discuss it with any member of my staff, with whom I am very close, nor did I discuss it with Mr. McPhee because, in my view, I did not want to jeopardize anyone's position. I felt that on Monday morning or the day after my resignation, if I took anyone into my confidence, my staff or Mr. McPhee, they certainly would be asked who knew about this. On Monday or Tuesday morning, my staff and Mr. McPhee could say, "No, we did not know about it." That was a personal decision.

I have been a civil servant for six and a half years and I know how the civil service functions. It was my own decision not to jeopardize anyone's position either on my own staff or Mr. McPhee's. That was my own decision.

**Mr. O'Neil:** Could I ask why did you not go to the minister directly?

**Mr. LeBlanc:** I felt that it had gone too far. I did not want it to be said on Monday morning or at this committee, "But you did meet with the minister. What did he offer you?" Or, "What happened?" I wanted none of that. I did not want the minister to be placed in that kind of situation. I had reached a decision which, in my view, was irreversible.

**Mr. O'Neil:** If I may I am going to refer to the letter quite a bit. On the top of page two of your resignation letter, you mention: "The major concern which I wish to bring to your attention is the direction being given to multiculturalism since the removal of Mr. Welch as minister."

I wonder if you could expand on that. Why would you say that?

**Mr. LeBlanc:** The first part of my sentence?

**Mr. O'Neil:** Yes.

**Mr. LeBlanc:** I expand later on in my letter on the new direction being given to multiculturalism.

**Mr. O'Neil:** You refer to that as—

**Mr. LeBlanc:** I refer to that as political and partisan. It is in the other paragraphs.

**Mr. O'Neil:** Another comment you make there is on the demotion of your former deputy minister. Could you expand on why you feel it was a demotion?

**Mr. LeBlanc:** When a deputy minister is appointed chairman of a commission and reports to a deputy minister, in my view, that would be considered as a demotion. I am making a statement. I am not editorializing. I try not to editorialize.

**Mr. O'Neil:** Are you implying that there was interference with the previous deputy minister and that there were disputes?

**Mr. LeBlanc:** No, I am making a statement, and someone could correct me in civil service terms. If a deputy minister who reports to the minister becomes chairman of a board and reports to a deputy minister, is that a demotion or not? I am not making any allegations. I am stating a fact.

**Mr. O'Neil:** You would not care to say whether any friction existed.

**Mr. LeBlanc:** I am making a statement.

**Mr. O'Neil:** You mentioned that when the new deputy minister, Dr. Wright, was appointed there were dramatic changes on your return on February 5.

**Mr. LeBlanc:** March 5.

**Mr. O'Neil:** March 5, was it? You feel, in other words, that Dr. Wright was not being, as you would classify it, a civil servant, but he was subject to political leanings.

**Mr. LeBlanc:** Basically, what I am saying is that from what I saw from February 5 on there was a clear change in the direction of the ministry where what I consider to be political partisan influences were being brought to bear on our own programs. I am not imputing motives. I am trying to state what I saw when I returned to the ministry.

**Mr. O'Neil:** Going a little further down, you also mentioned: "I know that it is commonly understood here that the new direction is highly political and partisan." When you say it is commonly understood, in other words, there must be other people who agree with you that the ministry has taken new directions or political directions.

**Mr. LeBlanc:** I was in hospital for a week, and people were calling me at the hospital telling me about the new direction. I pleaded with people to allow me to recuperate. When I returned to the ministry, in my discussions with people at all levels they sensed we were in a new era; the words they used were "a partisan political era."

**Mr. O'Neil:** There were other people within the ministry who had worries about this?

**Mr. LeBlanc:** Yes.

**Mr. O'Neil:** You mentioned too "knowledge in the ministry that programs are being directly influenced by individuals who are neither elected members of the Legislature nor permanent civil servants with mandated responsibilities." I wonder if you could expand a little bit on that.

**Mr. LeBlanc:** I consider that people who work in line ministries with program responsibilities have a mandated responsibility to carry out certain programs. People such as the ones I mentioned who do not have those responsibilities are developing programs in the ministry. I gave one example in my letter, of Mr. Forster's involvement in the field and how that had repercussions on our own program.

In fact, if the chairman agrees, I would like to comment on that one, since the minister did refer to that.

**Mr. O'Neil:** I'd like you to expand on it, if you would, please.

**Mr. LeBlanc:** In my letter I actually state that it was not Mr. Forster, but it was Mr. Rocco Lofranco who accompanied Mr. Forster at a meeting with the First Canadian Portuguese Club on March 5. The meeting was attended by Mr. Forster; Mr. Rocco Lofranco; Mr. Saragoca, the president of the club; Mr. Santos, the vice-president; and Mr. Valter Lopes, the secretary.

It came to my attention because the president of the club phoned our branch—I am under oath; I realize that—and asked us why we were allowing branch staff to interfere in the guest list. Mr. Saragoca said that someone by the name of a Mr. Rachwal—he wasn't exactly sure of the name—accompanied Joe Forster and asked him to delete names of the members of the provincial parliament and other members of the New Democratic Party.

I have a staff person whose name is Rachwal. I called him to my office. I asked him first of all if he knew of the First Canadian Portuguese Club, and he said no. I asked him if he had ever met Mr. Joe Forster, and he said no. I subsequently returned a phone call to Mr. Saragoca to ask him what was the name of the person, because our branch was being accused of political interference. He again said that was the name.

I phoned Mr. Joe Forster and asked him if he met with this club on March 5. He said yes, he did, and he was accompanied by Mr. Rocco Lofranco. Which made sense.

They meant Rocco; they did not get the last name.

We then informed the president of the club that it was not a member of my staff, that it was a Mr. Rocco Lofranco who accompanied Mr. Forster. That was the end of that discussion.

I know Mr. Saragoca has said publicly that this is not true. But I can give you the name of the secretary, Mr. Valter Lopes, who was at that meeting. I can give you his phone number, and Mr. Valter Lopes will tell you exactly what happened.

**Mr. O'Neil:** In other words, that they were asked to delete those names from the list?

**Mr. LeBlanc:** They were asked to delete the names of the NDP members of the Legislature and other individuals who were known to be members of the NDP. The only reason I became involved was that they thought it was a member of my staff. We followed that—it took me approximately two weeks to get to the bottom of this story. I was as surprised and as shocked as anyone else reading Mr. Saragoca's reply to the question. Which I can understand; having worked in this field long enough, I could understand why someone confronted by the press would not want to become involved.

**Mr. O'Neil:** Mr. Chairman, when you're making your comment here about being influenced by individuals who are not elected members, are you referring there again to Mr. Cook? Would he be one of the people you would be speaking about?

**Mr. LeBlanc:** He would be one, yes.

**Mr. O'Neil:** Could I ask you now, has Mr. Cook been appointed as the chairman?

**Mr. LeBlanc:** I believe Mr. Cook was appointed chairman in January 1977.

**Mr. O'Neil:** Now that is chairman of what?

**Mr. LeBlanc:** He is chairman of the inter-ministerial committee on multiculturalism which our ministry proposed since our ministry in 1976 developed the multicultural policy and proposed a committee on multiculturalism be set up made up of line ministries and it be chaired by the deputy minister of either Education or of Culture and Recreation. That proposal was subsequently changed as it went through the social policy field. The chairman is appointed now by Mrs. Birch and the first chairman was Mr. Bob Cook.

**Mr. O'Neil:** Has Mr. Cook varied experience in multiculturalism? Has he quite a background?



**Mr. LeBlanc:** I don't know his full background, but from our understanding there was some consternation in our ministry when the appointment was made, because it was not what we had recommended. The change took place in social policy. What really happened was the creation of a very ineffectual committee and I've discussed this with the deputy, our minister, the former minister and with Mr. Cook himself. He, as far as I know, was responsible for organizing ethnocultural events in the Premier's office. Really, he could speak much better for his own background. That was his involvement in the field.

**Mr. O'Neil:** Is one of the other people you're referring to this Mr. Forster, who again you do not feel has had experience in multiculturalism, rather it's political experience?

**Mr. LeBlanc:** I would gather he had broadcasting experience and the other kind of experience.

**Mr. O'Neil:** Okay. Going down, I'd like to just touch on the guest list. I'm just sort of wondering why you would have some Conservative members there and some NDP but all the Liberals were left off that list. Maybe the minister will have something to say about that.

I know the minister made some comments—and I'm quoting again from the bottom of page two: "Another example of political intervention in programming is the recent selection of an advertising firm to conduct a race relations campaign for the ministry." You mentioned interviewing five companies. One particular company was hired and then a change was made.

**Mr. LeBlanc:** Mr. Chairman, in all fairness to the company, ACI was chosen out of five as being the best, the most competent, the most sensitive in this field. The committee was made up from two members from my branch, myself and an assistant and two people from the information services branch.

Five companies were asked to present a proposal in response to a letter. We gave them an outline of what we wanted and they were to come to us and prove their mettle, prove that they could do it. One company presented us a calling card and said: "We've done this before, we're good."

ACI actually developed a proposal, which I gather is being circulated. It is unfair to see that proposal as a proposal which they were going to implement. It was the tender proposal and that is a very important distinction. That was the tender proposal. In

other words, they were selling themselves to us on the basis of a short letter we sent to them.

When they were approved the minister did veto the company because he asked Mr. Forster to look at that proposal and Mr. Forster had not been involved in this. Mr. Forster recommended that on the basis of that tender proposal they not be hired. We met with Mr. Forster and we explained to him the difference and that there was some confusion. This was not what they were going to do; this was, in other words, the way they were selling themselves to us.

We had a meeting to clarify this in the minister's office—the minister; the deputy minister; Mr. Forster; the executive director of the division; Brain Shannon, his executive assistant; Barbara McConnell from information services; and myself.

We clarified what this proposal was. The minister understood—we all understood—this was not exactly what they were going to do; this was a tentative proposal. The green light was given—"Let's go ahead with this."—when everyone was on the same wavelength.

This meeting was held in late January. Everyone was present. They were told by information services to go ahead. Three or four days later they were told to put everything on hold, and they were taken off the contract on a Monday.

I was informed by Mr. Forster that it was from on high, from the Premier's office. He actually didn't want to get into it, but he did tell me that they had done work for the Leader of the Opposition (Mr. S. Smith).

When the committee made a recommendation, they made a professional recommendation. I would never ask someone who is coming for a tender whom they have worked for. And that is exactly what happened.

In all fairness to the company, if you have their proposal in front of you, that is not what they are going to be doing; that's how they sold themselves to the ministry, as the four others did. Once they got the contract, they were in the process of developing exactly what we wanted, as the minister said it was to be; \$60,000 was to be for billboards and a few other things. They knew exactly. So, please, in all fairness to that company, that is not their proposal.

**Mr. O'Neil:** Had the company been told that they had the contract; that it had been awarded to them?

**Mr. LeBlanc:** My understanding was that they were told by information services. It was a joint project; so the information serv-



ices branch advised them to go ahead. I believe they worked on it for four or five days. Then they were also advised by information services that it was going to be done inside. I gather they were remunerated for those four or five days; I am not certain of those details. It was through information services.

**Mr. O'Neil:** Possibly we could get the information as to whether they were given something for the four or five days.

Then you are saying you were told the decision to take this contract away from them came from the Premier's office?

**Mr. LeBlanc:** Yes. I was informed that there was a very serious problem with the company—nothing to do with their professionalism, with their expertise; I was told it had to do with the work they had done previously.

**Mr. O'Neil:** You don't know who it was in the Premier's office, do you?

**Mr. LeBlanc:** I did not pursue that question any further.

**Mr. O'Neil:** Going down again to about the middle of page three: "I am concerned that under the present setup Mr. Cook's influence is an important factor in determining our program activities. It is clear that this ministry checks out new proposals with the Premier's office through Mr. Cook."

Was this committee or this group not able to go ahead on its own and make decisions without getting this approval from the Premier's office?

**Mr. LeBlanc:** Which committee are you referring to?

**Mr. O'Neil:** The one you are referring to here.

**Mr. LeBlanc:** Actually, my letter is saying that the new initiatives that were being developed were being cleared through the Premier's office, through Mr. Bob Cook. In fact, any initiatives were cleared through him.

**Mr. O'Neil:** To move on to page four, I know some mention has been made about the moving of Ontario Welcome House. As the minister stated, it has pretty well been suggested by many people, both in his ministry and by other groups, that there was indeed a change needed. In other words, their location at 8 York Street is not a very good location; it is just not suitable.

There seems to be some implication here that I would like you to clarify for us, if you would. Many people feel that the change was needed. Your letter seems to imply that the move was political only.

**Mr. LeBlanc:** Mr. Chairman, I referred very briefly to Welcome House in my letter. It is unfortunate, from my point of view, that the Star saw fit to have a picture of me next to Welcome House. We have been discussing moving Welcome House to a better location for over three years. My concern was that in the Premier's letter to Mr. Baetz, everything was going to be moved at Welcome House—the whole multicultural package. It appeared that no distinction was being made between the different kinds of programs that come under the citizenship division.

I have no qualms about its moving to a better location. My concern was that it was being done, in my opinion, for political reasons. A large sum of money would have been spent to rehabilitate that building; yet there were very many concerns which we as civil servants were really not being given the opportunity to discuss. There were many concerns about moving Welcome House in that location. But it was a fait accompli, and we were in a sense rationalizing that move post factum.

The scene has changed since 1976. In principle, I have no problems with moving Welcome House. It was overblown in the Toronto Star.

**Mr. O'Neil:** Also in that same paragraph, referring to Welcome House, you say: "I have heard twice in the ministry that this new direction is dictated by a secret poll conducted for the Conservative Party of Ontario which indicated that if an election were called in Ontario, Conservatives would lose the ethnic vote in Metro Toronto." You very specifically mention there that you have heard this twice. Could you expand on that for me?

**Mr. LeBlanc:** I heard twice that this was the bottom line of the new direction. If you are asking me if I have seen the secret poll, if I know of the secret poll, the answer is no. I am stating that is what I was told.

**Mr. O'Neil:** Was there a poll?

**Mr. LeBlanc:** I have to believe the people who told me.

**Mr. O'Neil:** You were told twice?

**Mr. LeBlanc:** Yes. If you want to find out about the poll, I think I would not be the person to ask really.

**Mr. O'Neil:** What if I asked you where I could find out—in other words, if I asked you for the names of the two people or the circumstances in which you were told twice that there was a secret poll?

**Mr. LeBlanc:** I would prefer, if that is possible, not to divulge the names at this committee meeting of those two people.

**Mr. O'Neil:** Am I free, Mr. Chairman, to ask some questions of a couple of others when I am finished here?

**Mr. Chairman:** Yes.

**Mr. O'Neil:** I think I have touched on as many things as I want to, so far as Mr. LeBlanc is concerned. I know some of the other members are going to have some questions. For clarification, however, could I ask the minister if there was a secret poll and if it pertained to the workings of this section of the ministry?

**Hon. Mr. Baetz:** Mr. Chairman, I can tell you that if there is a secret poll, I as a member of the cabinet have never seen it. I don't think there is a secret poll. I think it is a lot of talk. There may be. I suspect, as a member of cabinet, that I would hear of it. And I have never in my life heard of it until that came up.

As a matter of information, I should also say that I am given to understand that this Mr. Cook of the interministerial office is a civil servant. He does not fall in the category of being neither a civil servant nor elected. He is a civil servant, unless someone has given me the wrong information.

**Mr. O'Neil:** Mr. LeBlanc, getting back to this poll, the minister says he is not aware of a poll. Are you aware of any polls that have been taken by ministry staff or within the ministry or by any committees, interministerial committees or any other groups within the Ministry of Culture and Recreation or done by staff on their own perhaps?

**Mr. LeBlanc:** Not a poll. One of the activities my branch and the division took upon itself, actually while I was away, was a monitoring of the ethnocultural press. I would not view that as a poll. It was monitored to see exactly what was being said about government policies and programs. I would not consider that a poll.

**Mr. O'Neil:** I made mention back here about the invitation list for some of these things. It is a concern, I think, of some of the members of the opposition parties. The minister is new in the ministry, and these are things he is going to have to contend with in the future. There is some concern that some members of the Conservative Party are given fairly high profiles by ministry staff—maybe not just by your ministry, but by other ministries, too. Is there any policy that is followed, that is laid down in other words, when you are having dos like this, are certain people

to be invited and others are not to be invited? Are you aware of any? Maybe it is not fair to ask you, when you are new, but I think it is important.

[4:45]

**Hon. Mr. Baetz:** Well, I am new and not that new, but, no, it varies from event to event. As we have heard, the decision was made to keep the dinner in question very informal. Invitations went out to the local sitting members. One happens to be—I think her name is Nicholson. You were worried about the absence of Liberals and I think she is Liberal, is she not? But she is the federal member.

**Mr. O'Neil:** The federal party has nothing to do with us.

**Hon. Mr. Baetz:** All right. Anyway, the rationale was to invite the sitting members and that's why Mr. Ross McClellan got an invitation—

**Mr. O'Neil:** He might get one, but, as I say, this is something I think your ministry should look at very carefully. Possibly it should be looked at right through.

**Hon. Mr. Baetz:** On the visibility part of it, if I may just respond to that part of your question, I can assure you and everybody on this committee, and anyone else who is interested, that I am deeply committed to multiculturalism. I have worked for many years with all kinds of ethnic groups in Europe, in Asia, in the Middle East and in Africa, and I fully intend to be very visible with these groups. I have been visiting them a lot and I am going to continue to do so. I shall apologize to no one for that. I think that is my job. If that is being political, then I guess I am political, but I certainly will be continuing that practice.

**Mr. O'Neil:** In the Premier's letter to you of February 27, 1979, the Premier mentions: "I know about the new initiatives that you are planning in Culture and Recreation." Could I ask what those new initiatives are; what direction they take?

**Hon. Mr. Baetz:** I think there were a number of them. I am not even sure but he may have had the move of Welcome House in mind. This question had been under study and I have visited Welcome House. I sensed, as so many others before me had, that it is really in a bad location. There is certainly no ready access, particularly for the people using it. It should be moved into the centre of town. That was an initiative on our part that I guess the Premier had heard about.

There were a number of other things under consideration, but I really don't know what



more he had in mind. My reply would have been, "Well, what we plan to do with Welcome House"—that was the big thing at the time.

**Mr. O'Neil:** I don't know Mr. Cook and I don't mean to slur the man, but could you tell us why a person like that, who seems to have very little experience in multiculturalism, would be appointed as the chairman of that interministerial committee?

**Hon. Mr. Baetz:** No, I couldn't guess at this point, I had nothing to do with the appointment; I am not privy to the pros and cons. I would not accept the implied assumption in your question that he is not qualified. I suspect he probably has some qualifications, obviously, or he wouldn't have been appointed.

**Mr. O'Neil:** Mr. Chairman, I have no more questions; not at this time, anyway.

If I might just finish with one more and possibly direct it to Dr. Wright, if I am allowed to ask Dr. Wright a question. Is Dr. Wright aware of any poll taken that would give him, as deputy minister, and the ministry a direction to follow?

**Dr. Wright:** No, Mr. Chairman, I have never seen or heard of any such poll until I saw Mr. LeBlanc's letter.

**Mr. O'Neil:** Thank you.

**Mr. Grande:** Mr. Chairman, I am going to be very specific in two or three areas: the monitoring of the ethnic press; and also, by and large, the Outreach program.

I am not as concerned as others may be about the movement of Welcome House. Certainly the minister did say that discussions have been going on since 1976. Of course I am concerned with what goes into Welcome House.

But let me begin with the ad campaign and before I do that, Mr. Chairman, I would like to ask for certain materials to be provided by the Ministry.

Since we hear so much today about the interministerial committee on multiculturalism chaired by Mr. Cook, and since we also heard that Mr. Philippe LeBlanc was the person from the Ministry of Culture and Recreation on that committee, would it be possible, Mr. Minister, to have the minutes of that interministerial committee, beginning from the year 1977 when it was struck to the present time? Then we could see what is the work or the discussion within that committee. I understand that it comes under the Provincial Secretary for Social Development (Mrs. Birch); however, I am not asking for anything that comes under the ministry—

only the minutes that your ministry has in relation to that committee.

Secondly, would you be able to make available to the committee any of the work that the information services branch of your ministry has done in terms of increasing visibility, or in terms of the ad campaign for the race relations study?

If you could answer those, I think those are papers that I would certainly be very much interested in obtaining. I guess they won't be able to be obtained on the spot—there is no doubt about that—but I would like to have them.

Another thing that can be tabled with the committee is the letter that was sent on March 19, 1979, the memorandum to Dr. Wright from R. W. McPhee, executive director of the citizenship branch, in which the progress report of the multicultural Outreach project is outlined.

I think those are all the papers I will be needing. So let me ask some specifics about the ad campaign to start off with. My questions are more directly related to the minister and to the deputy minister. As far as Mr. LeBlanc is concerned, if he has anything to add I would appreciate it.

In the tender to these five companies for that ad campaign, one of the goals of the particular proposal is to identify the involvement of the minister and the Ministry of Culture and Recreation in race relations? Is it standard that a project that is contracted out would identify the involvement of the minister? Could the minister answer, how does the identification of the minister with the program help to alleviate the race relations in this province?

**Hon. Mr. Baetz:** As far as I know, it is not standard in these tenders to ask that proposals identify with the minister. I may be wrong, but certainly I have never asked anyone to do that. I am not aware that that is done; I don't think it is done. I think perhaps what you are referring to is that in this proposal there was a suggestion that I should get high visibility, or something like that; that I was sort of a nice guy and my image could be projected.

I must admit I was embarrassed at that suggestion. In the light of the present circumstances you may regard it as ironic that in spite of that I said it was a poor proposal. It was. It was too elaborate, it was far too expensive, and the program suggested here could not have been carried out within the time framework we had, which was very limited.



**Mr. Grande:** But, Mr. Minister, I have in front of me a copy of that particular proposal, dated January 8, 1979, and sent to Mr. Ernest Ford, J. Currie Advertising Limited, and the standard copy that is attached to that—and as it's a standard copy I would assume that every minister in the government uses this particular copy—it says under "goals:" "To improve the social climate among majority and minority groups (a) in select geographic areas, (b) province wide." The second goal is: "To identify the involvement of the minister and the Ministry of Culture and Recreation in race relations."

First of all, you said it is not standard.

**Hon. Mr. Baetz:** I said not that I know.

**Mr. Grande:** I see, all right. But, the second part of that question is how does your involvement as a minister resolve the racial tensions that we might or might not have in this province? I don't understand. Would you please clarify that?

**Hon. Mr. Baetz:** In the field of race relations, which is a very personal field, I think anyone—I suspect even Mr. LeBlanc, the director of the multicultural division—would say that in the field of race relations, multiculturalism, the more personal involvement one can have with the groups, with the individuals involved, the better it is. We should avoid the kind of impersonal service delivery we sometimes experience with other programs where they are sometimes very appropriate, but in the field of race relations and multiculturalism I see nothing wrong with the minister of the day being identified as having a very deep personal concern about it.

I can tell you I'm not the only minister who feels that way. I bow to the expertise of my federal counterpart, Mr. Cafik, for having done exactly that. He makes many personal visits, he is very visible, he is very much known in the ethnic communities, and I think, because he has been able to do that, he has done an effective job.

**Mr. Grande:** Then, Mr. Chairman, the minister is answering the question by saying that the Liberal Party of Canada does the same thing.

**Hon. Mr. Baetz:** Not necessarily.  
[5:00]

**Mr. Grande:** That's what you're saying to me.

**Hon. Mr. Baetz:** No. What I am saying is within the Liberal Party of Canada—which I think has a reasonable track record on multiculturalism—people like Mr. Cafik have done an effective piece of work.

We can get very, very cynical about that and say it's simply an effort on the part of the Liberal Party to promote Mr. Cafik or to promote the Liberal Party. The motives often are in the eye of the beholder.

**Mr. Grande:** That is one way you can deal with it, instead of giving me some basic reason. I'm not saying you should not go to ethnic dinners, or you should not go to these particular places. It is your job and it is your business what you do there. All I'm talking about is government money that is being spent on an ad campaign to identify the involvement of the minister. Now I don't understand how that is going to affect race relations.

**Hon. Mr. Baetz:** I thought I had told you that. I thought I had answered that.

**Mr. Grande:** Fine.

**Hon. Mr. Baetz:** I thought I had answered that. I want the ethnic communities, all of them, to understand this minister is interested in race relations and he's interested in multiculturalism.

You know yourself that it's easier to personalize a program if you can hang a name onto something or put a face to it.

**Mr. Grande:** Fine. Obviously, I don't quite see it that way. The increase in the visibility of the ministry I can understand. The increase in the visibility of the programs the ministry is involved with I understand. The increased visibility of the minister, I consider to be very partisan and very political.

The next one is in terms of the ethnic press review. I have something in front of me—a page, I guess, which comes from some other study. It says: "The purpose of this overview is to identify issues that are specific to the relations of Ontario's ethnic communities with the government as these are reflected in the ethnic press. This includes comments on existing government services and may be particularly relevant to an ethnic community and also reporting on needs that may not be met at present, but which are seen by the press as being the responsibility of the government."

Let me ask you this: Regarding this ethnic press review, who pays for it?

**Hon. Mr. Baetz:** We're getting into a detail here. I wonder if Mr. McPhee shouldn't be called upon to answer.

**Mr. Grande:** Fine. You can call anyone you want.

**Hon. Mr. Baetz:** Maybe he's not the appropriate one.

**Mr. Grande:** Perhaps your deputy minister could assist you on that.

**Hon. Mr. Baetz:** He'll give you a more precise answer than I would be able to without my notes.

**Mr. McPhee:** Which question, Mr. Chairman?

**Mr. Chairman:** Will you repeat your question, Mr. Grande?

**Mr. Grande:** The question, Mr. McPhee, is this: On the first page of a document produced in the Ministry of Culture and Recreation it says: "Multicultural Development Branch, Ministry of Culture and Recreation, Ethnic Press Review," dated March 1, 1979.

"The purpose of this overview is to identify issues that are specific to the relations of Ontario's ethnic communities with the government as these are reflected in the ethnic press. This includes comment on existing government services and may be particularly relevant to an ethnic community and also reporting on needs that may not be met at present, but which are seen by the press as being the responsibility of a government." The question that arises out of that is, who pays for that ethnic press review?

**Mr. McPhee:** Mr. Chairman, I think to answer yes or no or who pays without an opportunity to put the documents Mr. Grande is reading from in context, would be somewhat misleading. I would like that opportunity.

**Mr. Chairman:** I think you should have it.

**Mr. Grande:** All right, would you take that under advisement?

**Mr. McPhee:** I am prepared to do it right now.

**Mr. Grande:** Go right ahead then.

**Mr. McPhee:** I am just saying that you ended, Mr. Grande, by asking me who pays. I want to say a little more about the program and the documents which you have and I apparently do not.

**Mr. Grande:** I just have one sheet of the document. If you want to peruse it, that is fine.

**Mr. McPhee:** First of all, the documents being reported from and the one that you ended, Mr. Grande, by asking me who pays. I want to say a little more about the program and the documents which you have and I apparently do not.

It is a two-way direction: one, convincing Ontario government ministries that the population of this province has so changed that many of its delivery systems are simply outmoded. We see the multicultural development

branch as having a very important internal advocacy role. For example, in the recent throne speech, we combed it looking for examples of campaigns that other ministries are to carry out. We noted one, for example, on nutrition. You know that many people have come from countries with eating habits where, if they are to follow the same diet, they have to go to high-priced specialty shops. So we want the Ministry of Agriculture and Food, in their campaign, to take into consideration the needs of people who may not be familiar with how to meet their diet and their preference with food resources available here. That is the Outreach program and we want ministries to do that in as many languages as possible, but also to overcome the cultural barriers.

The other direction is that the government must be aware of the communities and what they think and their comments upon the services. There is nothing very new in this. I, as director of the human rights commission, under a period of constraint had to close regretfully, a storefront on College Street which provided this kind of service. What we see is putting our direct services—for example, we have four multilingual translators in the Macdonald Block; we think by moving them to Welcome House they will be more fully utilized. Also, because of their language capacities, they will be able to provide us with hard information on how the multilingual press of Ontario view the services that are being provided. It is a better utilization of the resources we already have. In that sense, until Mr. Baetz and the cabinet tell me that I have a lot more money to work with, we are seeing a much better deployment of our present resources.

**Mr. Grande:** Mr. McPhee, if I understand you correctly, you are saying the Ministry of Culture and Recreation pays for it.

**Mr. McPhee:** That is correct.

**Mr. Grande:** That is all I wanted to find out.

Since the minister was stating before, in reply to a question I asked, that he wants to get around to all the ethnic communities, groups, et cetera, would it be fair to say that those ethnic communities would inform the minister of their particular needs? Would it be fair? Is that an assumption or not? Or is the minister not approachable?

**Hon. Mr. Baetz:** That who would make me aware of the needs?

**Mr. Grande:** You were saying you have visited as many ethnic groups and functions in the province as possible. Would it be fair to assume those ethnic communities whose



dinners you attend, would bring you up to date in terms of their needs? Is the only way the ethnic communities have of reaching you through the ethnic press?

**Hon. Mr. Baetz:** No, not at all. My personal visits are only one form of communication obviously. I can't get around to all of them every month. We are in constant communication with many of them but, as I said, I want to step up the personal contact.

**Mr. Grande:** I have another question regarding this to the minister or anyone else who can answer it. On the monitoring of the ethnic press, is the material you monitor available to the other political parties in this Legislature since it is paid by taxpayers' funds?

**Mr. McPhee:** Again Mr. Grande is asking questions about a new program development for which the first organizational models have not yet been designed, let alone put before the deputy or the minister. We do have a working party, of which Mr. LeBlanc was a member, which is doing that. However, that certainly is a legitimate situation. In a sense, you are asking me the colour of the baby's eyes before it is born, Mr. Grande.

What happened, to put the thing in context, is that we are designing a new program. We are delighted as civil servants that the government is supporting something we have been asking for for many years. We hope this will be a full service to the entire community. For example, in our native branch we are doing the same thing. It is part of our intention to make the material available to all native groups, the same material we make available to government. That may well be one of our recommendations.

The whole project was interrupted because this ministry thought its estimates would be in October. We suddenly found they were now and that program came to a complete halt. As we develop some models, I am sure the ministry would welcome suggestions from all quarters. Certainly we plan to consult with the community and indeed we regret what has happened because it may give the community the impression they will not be consulted.

**Mr. Grande:** If one of the ways the Ministry of Culture and Recreation or the minister sees of finding out the needs of the community is through the ethnic community press, then I really don't know what other means of consultation there are. I guess the ethnic community should be going to the press every day.

**Mr. McPhee:** That was one possible method, Mr. Grande. The other proposal you

will see in there is that all MPPs would have access to Welcome House to meet people there and to have use of the translation services that are there and will be there.

**Mr. Grande:** Mr. McPhee, as I said at the very beginning of my leadoff speech, I have been around this ministry for the past almost three years. This is my third set of estimates. It is clearly the first time that I have heard about this multicultural Outreach program. Let me tell you, I am heavily involved in that field.

The government has the Ontario Advisory Council on Multiculturalism and has set up the interministerial committee on multiculturalism. Did any of these proposals come through the Ontario Advisory Council on Multiculturalism, which, as far as I am concerned, was set up to advise the government on the needs of the communities? Did it come from that route and, if it did, can you show me a report or any internal documents from that advisory council on these particular things you are doing here?

Perhaps it might be more apropos for the deputy minister to answer that since he was responsible, for the one particular time, for the Ontario Advisory Council on Multiculturalism.

[5:15]

**Dr. Wright:** I don't have with me a detailed list of recommendations of the advisory council over the last several years—since it was established. But, as I recall, it has made recommendations to government, on numerous occasions, to direct the ministries to become more sensitive to, and to communicate better with, the various ethnic cultural communities. The details of the program that Mr. McPhee was speaking about, I think, could be shown to be in harmony with many elements of those recommendations.

**Mr. Grande:** To monitor the ethnic press?

**Dr. Wright:** I think in order to be in touch and to comprehend what is going on. This question of monitoring: You may know, Mr. Chairman, two parallel documents are circulated widely now and used quite helpfully around government. One is a monitoring of daily papers from coast to coast. I think it comes from the Ministry of Intergovernmental Affairs. The other, covering press in Quebec particularly, comes from time to time. Particularly in the latter example, it's helpful to have these available in translation because not everyone can read French.

In the same way, having the editorial content and important lead articles from the ethnic press is indeed very helpful to the



communications branches of other ministries. They may uncover evidence of the failure to communicate. Most of the ministers' information programs, that is, other ministries, to my knowledge are not very well designed in terms of communicating with the real make-up of Ontario's population.

**Mr. Grande:** Mr. Minister, if the monitoring of the ethnic press—and I doubt that it will get started—does happen, could you give a commitment right now that this committee and the other two political parties in this Legislature will get copies of that press review?

**Hon. Mr. Baetz:** Without knowing the details of the as yet unborn child, I certainly would say, in principle, that that's exactly what would happen. If this is a program that will be financed by the taxpayers, it elicits information that is of public interest. Obviously, it should go to all political parties and maybe it should go to a broader public.

**Mr. Grande:** I would assume then, Mr. Minister, that you are making a commitment that the other two political parties will have access to that, if the baby gets born?

**Hon. Mr. Baetz:** I think that certainly is a commitment. Good. Good.

**Mr. Grande:** Some other questions, and perhaps it is more apropos for Mr. McPhee to answer them.

**Mr. Chairman:** Mr. Grande, excuse me. I don't want to interrupt your train of thought but time is moving on. I wonder if you would agree that your line of questioning would perhaps be more appropriate during estimates consideration? A number of other people would like to ask Mr. LeBlanc questions.

**Mr. Grande:** The Liberal critic was allowed to go from Mr. LeBlanc to the ministry, so I would assume that I will also be allowed that opportunity.

**Mr. Chairman:** Yes, I am just alerting you to the fact that a number of other people would like to question Mr. LeBlanc. Perhaps, if we could complete before 6, it would be—

**Mr. Grande:** Well, sir, I will try to be as fast as possible. I can assure you I am only going to be touching on the relevant issues in this particular thing. I will do it as fast as possible.

Mr. McPhee, there is some memorandum in existence, dated February 22, 1979, to all staff of the citizenship division from Robert W. McPhee, executive director, which states:

"Subject: Special Multicultural Outreach Committee." In that particular memorandum—and I'm reading from a sector in the second paragraph—it says: "Because this is the highest priority of the division, I have given the committee power to second any staff resources in the division for specific tasks."

It is a fact: that memorandum does exist?

**Mr. McPhee:** Yes, it exists. It was written by me with great enthusiasm. As you know, from previous estimates, Mr. Grande, we've always had a feeling that our division was somewhat neglected and we are very anxious to take full opportunity of this pregnant moment to develop some hard services.

**Mr. Grande:** I don't know what's pregnant about this moment that was not four years ago.

**Mr. McPhee:** Mr. Grande, if I may answer your question.

**Mr. Grande:** Sure.

**Mr. McPhee:** The opportunity to give these programs a greater utility or a greater effectiveness, to bring together skills that may now be in different parts of the division, and to maximize our effectiveness, I regard as the very highest priority of this division, without question. That includes, for example, a new assignment we just received from a committee of three ministers. If this is political direction, I accept it.

That direction was to do an inventory and co-ordinate the activities of Ontario ministries with respect to race relations. At the moment, I have two staff of the multicultural development branch trying to prepare this inventory of every race relations activity carried out by any ministry in this government. When we see what the results are we will do some analysis and make a recommendation which, I hope, will end up with a much more effective addressing of the problems particularly of the visible minorities. This is a high priority, without apology.

**Mr. Grande:** I refer to the document on the progress report of multiculturalism on each project sent by you to Dr. Wright. I guess this is the document I would like the committee to have in its possession, not only me. In that, you talk about the moving of Ontario Welcome House and you also talk about the possibility of 25 people being in Ontario Welcome House and, as well as those, you have the need to add five public relations people in your proposal. Is that a fact?

**Mr. McPhee:** You're referring again to one of the first thought pieces. As all my colleagues here and Mr. LeBlanc know, as

recently as one day before he left, we were gathered in my office with the flip chart trying to draw various organizational proposals. That particular document is a thought piece, and there will be many more.

**Mr. Grande:** A think tank.

Some of the thoughts are that the ethnic media liaison function should be located at Ontario Welcome House. You feel one individual with a reasonably high classification could handle this, plus the general PR for Welcome House.

Another is that one of the vacant PRO-2 should be used to engage a person with public relations and writing skills to develop the passport idea, prepare brochures, et cetera. One of the vacant PRO-2 could be used to engage a media relations officer for 1977 to ensure the minister's speeches get covered, and more press releases are sent out. Is that a political function or is it not a political function? That is what I'm trying to get at.

**Hon. Mr. Baetz:** I think there is a bit of paranoia here. I'm beginning to think you're a bit paranoid.

**Mr. Grande:** As I said to the minister from the very beginning, I want to clear the air for the Ministry of Culture and Recreation so it has solid credibility in the communities.

**Hon. Mr. Baetz:** I am replying to that. I am telling you they will be sent every speech I give that has any conceivable interest to the ethnic communities, with no apologies.

**Mr. Wildman:** Out of Welcome House?

**Hon. Mr. Baetz:** Out of whatever. Why not? If I have a speech on multiculturalism or interrelation—

**Mr. Wildman:** Your speech dissemination will come out of Welcome House.

**Mr. McClellan:** You don't see anything inappropriate about this, do you?

**Hon. Mr. Baetz:** No, why?

**Mr. McClellan:** That is your problem, sir.

**Hon. Mr. Baetz:** Perhaps you will have to elaborate a little more.

**Mr. McClellan:** Does the district director of the regional office of social and family services in Toronto assume the responsibility for disseminating the minister's speeches to the press, or does the regional office of any ministry in this government assume the responsibility of public relations for the minister? I think not, sir.

**Hon. Mr. Baetz:** I think if the Minister of Agriculture and Food (Mr. W. Newman)

makes a speech that is of interest to the Ontario Federation of Agriculture, his ministry will surely see that they get a copy of the speech. I am not for one minute suggesting that every speech I give, whether it be on arts or whatever, would go to a particular ethnic community if it's of no interest to them.

**Mr. McClellan:** We understand the wording of the memorandum right there.

**Mr. Grande:** Indeed, with great clarity. In the minutes of the interministerial committee meetings, just to correct the minister, when that committee was set up, the former Minister of Culture and Recreation said the purpose was to sensitize the public service to the needs of the multicultural society. What I see happening is that we are moving not to sensitize but to publicize and if the minister says that to sensitize public servants and to publicize are one and the same thing, I guess that's the minister's impression once again. Is what I am saying fair or am I putting you on the spot?

**Hon. Mr. Baetz:** To sensitize, to publicize; maybe if you would define your words, or if you don't want to define them, describe what you mean by these two words, then I will respond because I can't respond if you simply say "sensitize" and "publicize."

**Mr. Grande:** What is this committee then, Mr. Minister—or the deputy minister can answer that, since he was heavily involved in it—what has this ministry done in order to sensitize the public services within the Ministry of Health to deliver proper services to the people in those ethnic communities? What has the minister done? What has happened there? What about the Ministry of Community and Social Services? What has this committee done to sensitize the civil servants to these particular needs?

**Hon. Mr. Baetz:** Mr. Chairman, I would ask you whether or not we are getting really far off the subject here.

**Mr. Grande:** No, we are not, because the interministerial committee was to do exactly that and for many years I have heard the multiculturalists should pervade all the ministries and not just the Ministry of Culture and Recreation. That was the basic tenet of the whole thing.

**Mr. Chairman:** I think that's a very legitimate point we could discuss under vote 3004, Mr. Grande, but as we do have Mr. LeBlanc here, I think there are a number of members who would like to ask questions of him. Your comments are quite appropriate under the estimates but I wonder if we shouldn't



address ourselves to Mr. LeBlanc. After all, he is here. He was good enough to come to the committee and make himself available to explain some of the press statements and his letter of resignation and so on. I think the thrust of the committee's comments should be directed at Mr. LeBlanc and if the minister or his staff has to respond in terms of clarification, so be it, but that's where the major thrust at this point in time should be directed.

**Mr. Grande:** I accept what you are saying, Mr. Chairman, and we will come back to these questions.

**Mr. Chairman:** Thank you, Mr. Grande. Mr. Sweeney.

**Mr. Sweeney:** Thank you, Mr. Chairman. Mr. LeBlanc, in your opening statement, I copied down the following "funds to help immigrants diverted to political gain." Can you specify programs that had been in place to help immigrant people coming into this province that in fact had the funds diverted away from them and towards political gain?

**Mr. LeBlanc:** Mr. Chairman, would you—

**Mr. Sweeney:** That was your opening statement.

[5:30]

**Mr. LeBlanc:** In the opening statement; oh, yes.

**Mr. Sweeney:** Let me put it quite bluntly, Mr. LeBlanc. Of all the things you said, that to me would be the most worrisome. I'm not at all surprised that this or, quite frankly, any government tries to get some gain or benefit from the fact that it helps various groups in our society. What would concern me very much, though, would be if funds that would normally and had been directed towards programs to serve a group of people were redirected towards political gain. That is something much more serious. If you can support that statement, I would be pleased to hear it.

**Mr. LeBlanc:** Mr. Chairman, I'm just trying to find the exact quote. I think I said "diverted resources." Part of the effort that has been going on in the ministry—and I have dated it since February 5—is a redirection which I have said to be partisan and political, and that a lot of energy, a lot of forces and a lot of resources have been diverted—and I use that word because I think that was happening—to create programs that would have a high visibility for the government and would be of benefit politically and in a partisan way. That's in terms of human resources—people who were involved in developing these programs.

In terms of funds, I mentioned in my letter, and it has been mentioned here, that to move Welcome House—and again I want to reiterate that this is something we have been discussing for a long time—and to spend \$1,000,000, if that is the total cost for renovating Welcome House, would be funds that possibly could better be used in terms of supporting, for example, the kinds of groups that we have been supporting under our grants program.

**Mr. Sweeney:** Mr. LeBlanc, were there any particular programs that were eliminated or reduced as a result of this "political activity"?

**Mr. LeBlanc:** What was happening, until the day I left, was really a rewriting of our whole program for next year because of the new direction and new responsibilities that were being given to the division, to our branch and to other branches. We had not completed the rewriting of what we call our MBRs, or management by results documents, which go to Management Board. In those terms, yes, the impact was that staff would be doing other kinds of activities which I considered to be in the context of partisan and political activities. Some of the activities that our branch was in the process of doing could not be done. For example, our MBRs for next year, 1979-80, will become inoperative in a sense because, with the staff and the resources that we have, we would not be able to do what we had developed and planned to do.

**Mr. Sweeney:** Are you telling me then that particular programs that had been in place, or were contemplated to be put into place, have been reduced so that resources would be used for more political kinds of purposes? Is that what you're saying?

**Mr. LeBlanc:** That would be the impact of the new direction, yes. For example, someone was asking who was going to pay for the analysis of ethnic press. Those are resources. You need someone—you need people who know and can write languages—who can do this kind of activity. A number of other activities will have to be carried out within the existing staff component of the branch.

**Mr. Sweeney:** These are people who would otherwise be involved in more direct services to people?

**Mr. LeBlanc:** I am not certain what you mean by direct services. They would be involved in delivering the program activities that we had developed for this fiscal year under the MBR process.

Our MBRs for the division are up in the air, because everything is being revised and



is being changed. So what happens when all that is filtered and sorted out certainly will be very different from what we had been contemplating and planning, and what we had been doing for the past three years.

**Mr. Sweeney:** When was the decision made to move Welcome House to its projected location?

**Mr. LeBlanc:** I gather you could ask—

**Mr. Sweeney:** You don't know? May I redirect that question then?

**Hon. Mr. Baetz:** It was a process over a period of time.

**Mr. Sweeney:** When was the decision made, period? I know it was under consideration.

**Dr. Wright:** I am not sure, Mr. Chairman, that the decision can be taken finally as having yet been made. It had been advocated for a very long time, as the earlier documents indicated.

**Mr. O'Neil:** There must have been something that brought it to a head, though.

**Dr. Wright:** Yes. In the discussions that Mr. McPhee and the minister have referred to, in early February, the idea was put with greater force to the Ministry of Government Services. But we have not yet had any formal approvals from them—or from Management Board, in fact—for the actual implementation of that. We are hopeful that will be the result.

**Mr. Sweeney:** What was the source of the greater force that put the project to the Ministry of Government Services?

**Hon. Mr. Baetz:** Having looked at the lengthening history of discontent with Welcome House—where it is currently located, being inaccessible and not really being an appropriate building for the work we have in mind—and being aware that there were some other buildings available within the target area, I took the initiative in a number of different ways to see what could be done to make the move.

**Mr. Sweeney:** Mr. Minister, would you not agree—and I need the answer to this to tie in with the point that Mr. LeBlanc is making—that it's a very unusual coincidence that, according to your own words, the possibility of moving Welcome House has been in the works since back in 1976, almost three years ago, but nothing really has been done about it?

It was talked about, it was considered, it was weighed, saying "Yes, maybe—" but nothing happened. Then a letter, dated February 27, 1979, came from the Premier, saying it would be an excellent idea to

relocate, and all of a sudden the decision was made. That stretches credibility.

**Hon. Mr. Baetz:** No. As a matter of fact, the decision was made before even that letter came. The consensus was reached among the relevant ministers—and don't forget there's another minister concerned here, the Minister of Government Services, whose ministry has the buildings. But there has been a growing consensus over the past three or four months that a move could and should take place, and the time had now come, because the buildings were there.

As in any family or in any other setting, you talk about something for a long time; there's a growing need, a growing consensus, and one nice day you say, "The time has come. Let's go; let's make the decision."

**Mr. Kennedy:** Are the funds in the estimates?

**Hon. Mr. Baetz:** As far as the building itself is concerned, that will be the responsibility of the Minister of Government Services (Mr. Henderson).

**Mr. Sweeney:** Mr. LeBlanc, regarding the Premier's letter to which you made reference, in the very first paragraph there is a sentence saying to the minister: "As you may be aware"—and I underline the word "may"—"we have recently taken steps"—and I underline the word "recently"—"to step up a small section in this office." Could you tell me what the significance of those three words is?

**Mr. LeBlanc:** No, really I couldn't.

**Mr. Sweeney:** Don't you think it's unusual for the Premier of the province to suggest to the minister that he may be aware?

**Mr. LeBlanc:** It seems to me you should direct your question to the minister. I really could not comment on that.

**Mr. Sweeney:** What does the word "recently" mean there? From what we have been told, this had been going on for a long time.

**Mr. LeBlanc:** I really don't have an explanation.

**Mr. Sweeney:** Are we talking about a different group perhaps?

**Mr. LeBlanc:** If I read the letter correctly, it seems to me the letter does not refer to the interministerial committee, but refers to something in the Premier's office, but I would not know.

**Mr. Sweeney:** Thank you, Mr. LeBlanc. May I redirect that question, Mr. Chairman?

What does the word "may" mean, Mr. Minister? Why would the Premier of the

province be saying to one of his ministers—how long have you been minister?

**Hon. Mr. Baetz:** Since August.

**Mr. Sweeney:** Why would he say “you may be aware”? That is a very significant—

**Hon. Mr. Baetz:** It may be a polite way of putting it, I don't know. “As you are aware,” “As you may be aware.” I think it is a choice of words.

**Mr. Sweeney:** What does he mean by—

**Hon. Mr. Baetz:** I certainly was aware, I can tell you, and I had been aware for many months before.

**Mr. Sweeney:** What does he mean by saying “we have recently taken steps”? According to your testimony earlier this has been going on for quite a while.

**Hon. Mr. Baetz:** It has, indeed.

**Mr. Sweeney:** Either you or the Premier were not aware of it then.

**Hon. Mr. Baetz:** I was not aware of some of the memos that had been written in the greatest detail. I had been aware—

**Mr. Sweeney:** No, no. The reference is to set up a small section in this office under Bob Cook. It is not referring to any memos; setting up a small section very recently under Bob Cook.

**Hon. Mr. Baetz:** I can understand that, but if a number of ministries would be involved in it, why not set up a small section under Bob Cook? Government Services would be involved, Culture and Recreation would be involved, other ministries would be involved, as well.

**Mr. Sweeney:** Why in the Premier's office? We are all aware of other interministerial committees that don't operate out of the Premier's office.

**Hon. Mr. Baetz:** Because this is where Bob Cook is chairman of an interministerial committee and if any number of ministries are involved in something, I don't see why it doesn't make a lot of good sense to set it up in the Premier's office if the personnel were there to do it.

**Mr. Sweeney:** I don't see where it flows. What other interministerial committees flow out of the Premier's office?

**Hon. Mr. Baetz:** You don't understand why the Premier's office wouldn't be an appropriate place?

**Mr. Sweeney:** No.

**Hon. Mr. Baetz:** Where would you suggest it would be set up, then?

**Mr. Sweeney:** In the policy division, policy secretariats, where all the other interministerial committees—

**Hon. Mr. Baetz:** Not necessarily, because you have a social policy, or a social development policy group, but the Ministry of Government Services is not a part of that. This whole program was cutting across all ministries, or most of them anyway, and possibly all of them. It is one of these things that doesn't neatly fall within any of the policy fields.

**Mr. Sweeney:** I don't consider those satisfactory answers, Mr. Minister, not at all.

**Mr. LeBlanc:** you indicated earlier in your testimony that there were quite a number of other co-workers, shall we say, within the ministry, who had expressed dissatisfaction with the—I will use your words—“political interference.” Did any of these express their dissatisfaction to the point of suggesting they also might resign?

**Mr. LeBlanc:** I think, Mr. Chairman, they expressed a lot of concern about this new direction, but in terms of your other question I really would not be at freedom to say where people are at really.

**Mr. Sweeney:** You are not aware of anyone else who has?

**Mr. LeBlanc:** I am not aware of anyone who has resigned, no, if that was your question; no.

**Mr. Sweeney:** On what basis would you reconsider your resignation?

**Mr. LeBlanc:** Reconsider not resigning, or reconsider what?

**Mr. Sweeney:** Well, reconsider the fact that you have tendered a resignation. Are there any conditions under which you would reconsider?

**Mr. LeBlanc:** I resigned really on a question of principle. It would be very difficult for me now, being a private citizen, to be satisfied the conditions under which I resigned exist or don't exist, so I just find it very difficult to answer your question really. When you are on the outside it is very difficult to know what is happening, so how could I reconsider my resignation? I resigned at a time over what I thought and I saw happening in the ministry. I resigned on a question of principle. Now I am on the outside, like a member of the opposition, I don't really know what is happening. Am I answering your question?

**Mr. Sweeney:** Yes, I think you are.

What is the significance of the fact that these rather dramatic changes took place in

the month that you happened to be away? Can you attribute any significance to that?

**Mr. LeBlanc:** I think it was providential. I don't see any significance. I had an accident. I could have had an accident—I had an accident, period.

**Mr. Sweeney:** You wouldn't suggest then that certain things were done precisely because you were not there?

**Mr. LeBlanc:** No, I would not suggest that. I have said in my letter and I have dated the changes, the new direction, with the arrival of the new deputy minister. I certainly would not say they happened because I was absent. There is no question.

**Mr. Sweeney:** Thank you, Mr. Chairman.

**Mr. Leluk:** I am going to be rather brief. What I would like is clarification of a point or an issue raised by Mr. LeBlanc. I believe, if my memory serves me correctly, you stated you were away from your post for approximately a month because of an accident and when you returned you found there had been some dramatic changes which had occurred with respect to new political directions in the multiculturalism division. Is that correct?

**Mr. LeBlanc:** Not immediately upon my arrival. It did take a few weeks for me to see exactly what had been happening.

**Mr. Leluk:** I am having some difficulty with a statement you made about the lack of communication between yourself and Mr. Bob McPhee, who is director of the multiculturalism division. My recollection tells me you didn't discuss your observations with him. I would like to ask, would you not agree common practice dictates if you had made certain observations you would have discussed these with Mr. McPhee, director of the multicultural division to see whether he shared these observations with you?

**Mr. LeBlanc:** One thing I did not discuss with Mr. McPhee, and that is what I stated, is my resignation. I gave the reasons why I did not discuss it with Mr. McPhee or members of my staff. However, I did discuss with a number of people within the ministry the new direction and what was happening.

**Mr. Leluk:** Again, if I understand the setup in the ministry, Mr. McPhee is director of the multiculturalism division, which would indicate to me he would be immediately above you. Is that correct in the way the thing is set up?

**Mr. LeBlanc:** That is correct, yes.

**Mr. Leluk:** Again you state you had no discussions with him.

**Mr. LeBlanc:** Concerning my resignation, yes.

**Mr. Leluk:** Let me phrase the question another way, then. Did you discuss with him your observations regarding these so-called new political directions in multiculturalism which you say you observed?

**Mr. LeBlanc:** We had discussions concerning what was happening in the ministry, yes, but in terms of discussing my letter in detail, and what I included in my letter, no.

**Mr. Leluk:** You are not answering my question, Mr. LeBlanc. The question I posed to you earlier was, would you not agree it would be considered common practice for someone in your position to have discussed with your immediate supervisor, who happens to be Mr. McPhee, the observations you claim you made with respect to these so-called new political directions in multiculturalism?

**Mr. LeBlanc:** What I am saying to you is that we had discussions about what was happening in the ministry, general discussions.

**Mr. Leluk:** Regarding the so-called new political—

**Mr. LeBlanc:** General discussions, but I did not discuss my letter of resignation with Mr. McPhee, or the fact that I was resigning, or the specifics of my letter. But yes we did, and I had general discussions with a number of people in the ministry, not only Mr. McPhee. I did not go to Mr. McPhee and say, "I am resigning and if these conditions are changed I am not resigning." I did not discuss my resignation with Mr. McPhee.

**Mr. Leluk:** You did not then discuss with Mr. McPhee the observations you made regarding these so-called new political directions in multiculturalism within the ministry to see whether he shared these observations with you? That is the question I am asking. I am not getting an answer.

**Mr. LeBlanc:** I thought I had answered. I said, yes, in general, I discussed with Mr. McPhee some of my concerns in terms of what was happening in the ministry, but not the specifics of my resignation, not all the specifics contained in my letter, no.

**Mr. Leluk:** Mr. Chairman, with your permission may I direct my question to Mr. McPhee then as director of the multicultural division? Did Mr. LeBlanc then, Mr. McPhee, discuss with you at any time these observations which he has told this committee he observed with regard to the new political directions in the multiculturalism division?



**Mr. O'Neil:** Mr. Chairman, I don't think Mr. McPhee has been sworn, has he? Should he be?

**Mr. Chairman:** No, he hasn't been sworn, Mr. O'Neil. I really don't see any point at this juncture. I'm sure Mr. McPhee is prepared to answer the question.

**Mr. McPhee:** Yes, Mr. Chairman, I think just to answer chronologically would be the clearest way to give Mr. Leluk an answer. Until I heard through the deputy minister that the Globe and Mail had called on Sunday, March 30, Mr. LeBlanc had my full confidence and was privy to my every thought, and I was privy, I thought, to his thoughts. We had many discussions about this and shared many concerns. Certainly some of his concerns which may be characterized as negative today would be ones I would have shared—no question about it. But we were a part of a team working together; indeed, even when he was in his hospital bed I felt apologetic for phoning him and giving him certain information before I left. I happened to be away at the same time he was. He seemed to have been under sedation and I felt guilty about trying to bring him up to date.

The memos Mr. Grande has were sent by me to Mr. LeBlanc's hospital bed. The last written word I had from Mr. LeBlanc was March 26, which was the end of the week he left.

I think this is a memo that should be tabled. It's re the multicultural outreach program; it contains many fine recommendations; it disagrees with certain of the earlier material; it states why. I think the spirit of our relationship is summed up in the last three paragraphs—and the spirit of his participation, even in the broader public program:

"A volunteer co-ordinator could arrange tours to the McMichael gallery or the Royal Ontario Museum. This was a successful program previously carried out by the International Institute.

"A public relations officer at Welcome House is an important position as this person would have to maintain information on groups and provide information to groups, should Welcome House become something akin to a community information centre. Newcomer services branch orientation material is not intercultural nor multicultural; it is not addressed to all Ontarians as is multicultural development branch material. Should the preparation of that material not be done at Welcome House?

"Bob, please consider the above comments as part of our contribution to the discussion around reorganization."

That was Monday of the week. On Thursday of the week Mr. LeBlanc joined me to come to Queen's Park to brief Mr. Baetz on a meeting he was to have with Mr. McMurtry and Dr. Elgie, Dr. Wright, the other deputies, on the whole question of race relations in the government.

I reported to Mr. LeBlanc on Friday that in my opinion that was a very successful meeting, and gave him the details. He seemed pleased. I was also in the building on Saturday and heard a noise in his area and knocked on the door and we had a friendly chat. Sunday, through Dr. Wright, I heard from the Globe and Mail.

That's the chronological account of what happened during the last week.

**Mr. Leluk:** May I follow up my question with this one? As a director of the multiculturalism division with the Ministry of Culture and Recreation, were you aware at the time Mr. LeBlanc resigned his post, or now, of any so-called new political directions in multiculturalism emanating from the Premier's office?

**Mr. McPhee:** No.

**Mr. Leluk:** Mr. LeBlanc has made some very serious allegations here that there has been political influence through the Premier's office. I would like to ask you that question.

**Mr. McPhee:** If the deputy minister is a political person then, yes, the deputy minister was quite clear that he wanted a stepped-up program in our area; no question about it. The minister has been quite clear on that this year. In terms of the race relations campaign, for example, that money was not in our budget; the minister took that from another part of the government. In terms of increasing the native community branch this year, the minister took something like \$150,000 or \$200,000 from another part of the ministry. I have been pleased, of course, that our division seems to be getting the recognition I believe it deserves in the ministry.

**Mr. O'Neil:** Were you aware of his political concerns, though?

**Mr. McPhee:** In the course of the consideration of the vote, I think a fuller answer should come out from my colleagues and Mr. LeBlanc's former colleagues, the program managers working on these details. There are 129 people in this division from a variety of religious backgrounds, humanistic, secular, but they are mostly people from the helping professions. Most of them see themselves as dedicated people of principle. I would not want you simply to accept my

word. I think we would have dozens of recommendations, and I would be the first to accept a four-point, rural United Church charge if I felt I was being politically dictated to.

**Mr. Leluk:** That answers my question. Thank you.

**Mr. Chairman:** Mr. McClellan, Mr. Blundy and Mr. Grande, I would like very much to finish this matter today, with the concurrence of the committee. If we could move along, I would appreciate it.

**Mr. Grande:** Which matter are you referring to?

**Mr. Chairman:** The matter with Mr. LeBlanc—so we don't have to bring him back tomorrow.

**Mr. McClellan:** I will be very brief. I just have one matter that I wanted to try to have cleared up, and I would like to have it cleared up while Mr. LeBlanc is with us. It is the question of what happened at the First Canadian Portuguese Club meeting that is referred to in Mr. LeBlanc's letter of resignation. I would like to ask one, or at most, two questions of the one person in the room who was present at that meeting, and that is Mr. Forster. I would ask if he could come to the table and be sworn.

**Mr. Chairman:** Presumably, Mr. McClellan, you are relating this back to Mr. LeBlanc?

**Mr. McClellan:** Yes. I just have one question of Mr. Forster.

**Mr. Chairman:** Do you wish Mr. Forster to be sworn, Mr. McClellan?

**Mr. McClellan:** Yes, please. I hope that will clear up the matter as far as I am concerned.

Joseph F. Forster, sworn.

**Mr. McClellan:** Mr. Forster, I would like to ask you about the meeting at the First Canadian Portuguese Club which has been referred to and which was attended by yourself and Mr. Rocco Lofranco, and by Mr. Saragoca, Mr. Valter Lopes and Mr. Henrique Santos from the First Canadian Portuguese Club. At any time during that meeting did Mr. Rocco Lofranco make suggestions to members of the executive of the club about names that should be deleted from the guest list?

**Mr. Forster:** I would like to answer that but, if possible, with an explanation. Yes Rocco Lofranco did make such a suggestion.

**Mr. McClellan:** Thank you.

**Mr. Forster:** May I give the explanation?

**Mr. McClellan:** Please do.

[6:00]

**Mr. Forster:** Mr. Lofranco met me at that club for the purpose of a subsequent meeting to that meeting with the First Canadian Portuguese Club people. He was not invited to that club to attend that meeting. He arrived; he interjected himself into that meeting. He was known to these people.

These people asked me about the dinner and said, "We're going to have a sit-down dinner downstairs; very formal, black tie." I said, "Let us have an informal dinner, a buffet, so that more people can attend—club members." They then said, "We are going to invite the following people. Would this be okay with you?"

Mr. Lofranco leaned forward, looked at the list, and said, "I don't see why you're inviting all those politicians." I interjected and said, "Rocco, it is not your place to speak." I said to the president of the club and the two members attending, "It is up to you people to decide who should attend, and no one else."

**Mr. McClellan:** I thank you very much, Mr. Forster, for setting the record straight. That is my understanding exactly of what transpired at the meeting, having talked to the people who were present.

Mr. LeBlanc has said, in his testimony, that there was no reflection on yourself; that the concern was with the attempt by Mr. Rocco Lofranco to censor the—if I may use my words now—the guest list.

**Mr. Forster:** In defence of Mr. Lofranco, I should say that he was asked his opinion directly and that's when he intervened. Then I said to him, "This is not your concern."

**Mr. McClellan:** If I may say so, Mr. Chairman, it sure as hell is a matter of my concern. Mr. Rocco Lofranco is the ethnic co-ordinator of the Workmen's Compensation Board and I don't know what he was doing at that meeting. I don't know what business it is of the ethnic co-ordinator of the Workmen's Compensation Board to give political advice to anybody, let alone advice on behalf of the Progressive Conservative Party.

I'm going to look at the transcripts in Hansard, because I have asked this question in the House—with a view to assessing the accuracy of the responses that were given—in the light of the testimony we've just received. I also intend to give a transcript of this exchange to the Minister of Labour (Mr. Elgie), who, I think, will be enormously



concerned about it, as I think most of us should be.

Finally, I want to say that my concern is not with this matter. It is not with Mr. Forster. Nor is it the concern of the First Canadian Portuguese Club with Mr. Forster. Nor was the complaint to Mr. LeBlanc's department made with respect to Mr. Forster. It was made with respect to Mr. Rocco Lofranco.

Not now, but at a subsequent time very soon in these proceedings, I will come back to you, Mr. Minister, to find out what's going on.

**Mr. Chairman:** A clarification, Mr. Kennedy?

**Mr. Kennedy:** Yes. Mr. LeBlanc, in his letter of resignation, said Mr. Lofranco, who was identified as someone who worked in the government, asked the president of the organization to delete from the guest list the names of the local NDP MPPs and other known members of the New Democratic Party who were to be invited to the dinner. So that's totally inaccurate?

**Mr. Forster:** Mr. Lofranco, as I recall his statements—and I am under oath; it may be verbatim—

**Mr. Kennedy:** I know. That's why I asked the question.

**Mr. Forster:** This list was presented to me and they said, "These are the people we're inviting. What do you think?" It was handed to Rocco Lofranco and he looked at the list and his statement was, "Why are you inviting all these political people? This is not a political meeting." I said, "Please, Rocco, this is not a matter that concerns you."

Mr. Lofranco came there to meet me for a personal meeting between the two of us. He was not invited to that club to attend that meeting. Therefore he arrived while we were still with the executive; I was with the executive. He then joined the table.

**Mr. Kennedy:** That obviously isn't what Mr. LeBlanc understood, from his letter. He says "local NDP members" in his letter of resignation.

**Ms. Gigantes:** They were local NDP members.

**Mr. Kennedy:** Your two understandings are obviously different.

**Hon. Mr. Baetz:** Further to that, I think the suggestion was made that Mr. LeBlanc had not implicated Mr. Forster. This is right, isn't it? Isn't that what you were saying? I think the record will show it.

**Mr. McClellan:** Just so I am clear, his statement today—I think I am recalling accurately; Mr. LeBlanc, as author of the statement, can correct me if I am wrong—is the complaint was with respect to Mr. Lofranco's intervention at that meeting. That was the complaint that came to the ministry staff, and that was the substance of the concern, as I understand it, in the letter of resignation.

**Hon. Mr. Baetz:** I would just like to read into the record, then, part of a paragraph from Mr. LeBlanc's letter of resignation, in which he says: "An example of partisan influence in our ministry is the appointment of Mr. Joe Forster as your communication adviser on multicultural affairs. Mr. Forster was well known for his work at CHIN radio and for his involvement in the Conservative Party of Ontario. As you know, he is presently working in the ministry developing multicultural communications that are now, in my view, more political than governmental.

"Also, his involvement with ethnocultural community groups has been detrimental to our branch's working relationship with these same groups. For example, he [Mr. Forster] convinced the Metro Portuguese group to arrange a dinner in your honour. At a planning meeting with the president of that group and members of his executive, Mr. Forster, accompanied by Mr. Rocco Lofranco, former co-ordinator of the community centre of the Conservative Party of Ontario, now co-ordinator, ethnic programs, Workmen's Compensation Board, reviewed the guest list for the dinner. Mr. Lofranco was then identified as the one who worked for the government," and so on.

But the point of the letter of resignation is Mr. Forster is certainly very much implicated with this Portuguese dinner and its planning.

**Mr. McClellan:** Did Mr. Forster tell you what he has just told this committee?

**Hon. Mr. Baetz:** Yes.

**Mr. McClellan:** Yes. You're in real trouble.

**Hon. Mr. Baetz:** I am simply saying here that Mr. LeBlanc has implicated Mr. Forster in his letter of resignation. Don't try to read into the record here that that is not the case.

**Mr. McClellan:** When did Mr. Forster tell you what he has just told the committee?

**Hon. Mr. Baetz:** I can't remember.

**Mr. McClellan:** You had better remember, because you said something in the House.

**Hon. Mr. Baetz:** You don't have to worry about what I said in the House.



**Mr. McClellan:** I don't have to worry about it, but you might have to.

**Hon. Mr. Baetz:** And I don't either.

**Mr. McClellan:** Don't be so sure.

**Mr. Blundy:** Mr. Chairman, I would like to ask Mr. LeBlanc a couple of questions, as well as the minister later on.

Referring to the letter of resignation which you wrote, Mr. LeBlanc, you said: "I have heard twice in the ministry that this new direction is dictated by a secret poll," and so on. You declined to offer the names of the two people from whom twice you heard that. Could you tell this committee whether these were people in the minister's office, or people from the Premier's office, or people from Cook's committee, or fellow workers in the ministry as you were?

**Mr. LeBlanc:** I have been asked those questions before. It is someone in the ministry, yes. I am a member of the interministerial committee on multiculturalism, so that would eliminate me. But I would ask, since it is someone in the ministry, that I not be requested to implicate anyone. The question has been raised, and I gather it has been asked of a number of people, about that secret poll. I have no more information than is contained in my letter, really. If I did, I would provide it to this committee.

**Mr. Blundy:** Would your reference to a secret poll perhaps have some relationship to what the Premier said in his letter to Mr. Baetz? I'm reading the last part of the second last paragraph: "We might soon regain the recognition lost in the past few years because of the wide proliferation of our multicultural efforts."

**Mr. LeBlanc:** I have no reason to agree or disagree. I really don't know. I can't interpret that.

**Mr. Blundy:** It seems to me the Premier is taking the view that that might have something to do with a poll, although he doesn't say that. I just thought there might be some reason for you saying that.

I would like to ask you if in this article in the Toronto Star you were quoted correctly. The paragraph above reads: "The head of this section, Bob Cook, chairman of the interministerial committee on multiculturalism, was described by LeBlanc, in his letter of resignation, as being preoccupied with the political side of multiculturalism." Then you say, and it's in parentheses: "'I was witness to questionable practices and interference in my department,' LeBlanc said last week. 'It's wider

than my branch and someone should look into it.'"

You are implying there, I presume, that the political interference you spoke of is wider in other branches of government, in addition to your branch of the government?

**Mr. LeBlanc:** This is a long interview, Mr. Chairman, and the question—and you're relating it to Bob Cook; I am not certain it was related to that conversation—the question that a number of people have put to me is: "Doesn't this happen in all ministries? Why are you getting so upset?" My answer has been, and will be to this committee: if it is happening in other ministries, I am not aware of it. I am aware of what was happening in my ministry. I was aware of what was happening to our programs, and I'm competent in that area, but I cannot answer for other ministries. So, while that was not misquoted, in a sense it was taken out of the total context of our conversation. So if someone were to ask me, I would say I had nothing to substantiate it. I can speak only for what I have been involved in for the past three and a half years.

**Mr. Blundy:** All right, thank you.

I would like to ask the minister, Mr. Chairman—I am making reference to the communications study. It says in Mr. LeBlanc's letter: "The company was informed of the minister's decision and told to go ahead with the campaign." Now, it went ahead and then a few days later it was stopped. I would like to know two things. By whom was the company told to go ahead with the campaign? Then, by whom was the company told to stop and not have anything further to do with the campaign? Obviously, at one point you decided, "Yes, go ahead"; and then, four days later, or something like that, you decided not to, or someone did.

**Hon. Mr. Baetz:** I would ask someone else on the staff here, perhaps the director of finances—or was it public information?—to give the details of the correspondence that went to the company. My own participation in all of this took place, I believe, on January 27.

[6:15]

Anyway, at the time that I saw this proposal by ACI, it was at that time I told the director of finance and administration and others who were there that I was not satisfied with the proposal at all because we were really under such a desperate time restriction and also because of the elaborate kind of proposal. If this was just another interim proposal, as Mr. LeBlanc has sug-

gested, and the company would have been prepared to go back and do some more work, I was not aware of that at the time.

I think that the most important point here was that we were running out of time. We didn't have time left before the end of the fiscal year to continue negotiating with a company on a project which up until then had been far too elaborate. When I had been convinced by my internal staff, Mr. Forster and others, that this is something that we could do very quickly and very efficiently with our own in-house staff and that we should go ahead and do it that way, my decision at that point was to drop this proposal and drop the company. I did not have any further communications with my own staff on who would write and who would tell the company.

**Mr. Blundy:** There wasn't any direction from anybody else or any document from anybody else, indicating that this should be done? You are saying that the decision was made solely by you to stop it.

**Hon. Mr. Baetz:** In my office with a number of staff, I have even forgotten exactly who was there. There must have been five or six people there. I do recall, and the director of finance and administration recalled this very distinctly this morning, my going to him and saying, "My goodness, this is too elaborate. It's too expensive. Are we required to go through this kind of an ad agency to get billboards?" As we know in some instances, one has to do that. The answer was, "No, of course not. We don't have to go through a middleman. We can do it ourselves." I said, "Why not save some taxpayers' money and do it ourselves then?"

**Mr. Grande:** Why did you not do it yourself before then?

**Hon. Mr. Baetz:** I think that was on January 27.

**Mr. Blundy:** Were there any minutes kept of that meeting that we could have?

**Hon. Mr. Baetz:** I don't think there are minutes of that meeting.

**Mr. Blundy:** There were no minutes of the meeting?

**Hon. Mr. Baetz:** No, I don't think so.

**Mr. Blundy:** So there is no document, no minutes or anything that we could ask to have tabled before this committee?

**Hon. Mr. Baetz:** No.

**Mr. Blundy:** Mr. LeBlanc, do you have any comments on the statement that was made by the minister here today after you made your initial statement? Are you prepared to make

any comments on any of the matters brought up in the minister's statement following your statement?

**Mr. LeBlanc:** Are you talking specifically of the communications proposal or generally?

**Mr. Blundy:** No, I am speaking about the general comments made by the minister after you made your initial statement here. Do you wish to make any further comments following the minister's comments?

**Mr. LeBlanc:** I have answered, I hope, most of the questions and the concerns that were raised. I would like to make one point in reference to Mr. McPhee's statement. He very factually said that until the last day, in fact on Thursday, I was briefing the minister on a human rights issue. I can assure the members of this committee that until Friday I did what was expected of me professionally. My personal decision, the timing and what I was raising in my letter, in my view was not something that I was going to bring up within the ministry. Up to the last minute, I worked on what I was supposed to do. Yes, I did brief the minister on Thursday the best I could. That's the only comment I wanted to make on Mr. McPhee's statement actually.

**Mr. Blundy:** My question to you was did you wish to make any comment on the remarks that the minister made today before this committee after your initial statement was made today?

**Mr. LeBlanc:** No. I have made this comment again. It seems to me there's some conflict or some contradiction in the chronology of what happened in terms of the public relations proposal. The last meeting we held was in the minister's office. I named the people who were present. Actually, the director of the information services was away on holiday, so his assistant was at that meeting. Everything was clarified as to what the proposal was because Mr. Forster raised a number of questions about the proposal because he was not informed as to what it was. It was on the basis of that meeting that the company was given the green light to go ahead and do it. The decision was reversed three or four days later but I was not that involved because I was told it was a political thing. I was only informed as to the decision, and in my letter I stated who informed me.

**Mr. Blundy:** You were not one of the people present when the decision was made. You were just informed of the decision.

**Mr. LeBlanc:** I was present when the decision was made with everyone present—the people I mentioned, the minister; the deputy minister; Mr. McPhee; Brian Shannnon, the executive assistant; Mr. Forster; Barbara



McConnel from information services branch; and myself. We clarified the questions that Mr. Forster had raised about the proposal since he had not been involved in this process. Then everything was clear and the green light was given.

**Mr. Blundy:** Thank you very much, Mr. LeBlanc.

**Mr. Chairman:** Mr. Grande, you have a question or two?

**Mr. Grande:** I have two questions as a matter of fact, Mr. Chairman. One is to Mr. LeBlanc. Do you have knowledge of the fact whether Welcome House right now, has five PR people in it?

**Mr. LeBlanc:** No, Mr. Grande. I've been away from the ministry for two weeks.

**Mr. Grande:** Before you left, while you were an employee of the ministry were you aware whether Welcome House at that particular time had five PR people?

**Mr. LeBlanc:** No. I was not aware of it and I don't think there were. I'm sure someone else could give you a more accurate answer.

**Mr. Grande:** I have a second question for Mr. LeBlanc. I understand that you started sometime in January 1976 with the ministry.

**Mr. LeBlanc:** January 1976, yes.

**Mr. Grande:** Bob Cook became the chairman of the interministerial committee on multiculturalism in 1977.

**Mr. LeBlanc:** January or February 1977.

**Mr. Grande:** Since you have all the information on what was going on in that committee, did you at any time have any concern about Bob Cook and the direction in which he was steering that committee? Was there any disagreement between yourself and Bob Cook about the direction?

**Mr. LeBlanc:** Yes, many times actually.

**Mr. Grande:** Would you be willing to elaborate on that?

**Mr. LeBlanc:** One of the first tasks of the committee—and I was supported by the ministry on this—was to review the grants programs of both our branch and the citizenship branch. It became very clear to the members on the committee that they were not qualified to deal with this because the committee was made up of people from other ministries. That was one source of disagreement. The first task of the committee was to review the grants, which it did. In terms of concrete proposals, for example, there was the exhibit in Queen's Park, which was a suggestion that came from our ministry and we actually carried it out.

It was always very difficult really to act. In my letter, what I stated was that his concerns and what I considered to be the concerns of our ministry, or the concerns I was raising, were not the same really. I was not concerned that the federal government was putting ads in the ethnocultural newspapers. If they wanted to spend their money doing that, I considered that to be a political concern, and it was raised many times.

**Mr. Grande:** Today in your testimony you were saying that the ministry began this political turn, or became more political, once the deputy minister was appointed. Since that particular time in your dealings with Bob Cook, between that time and the time you resigned, did you have any, what I would call disagreements?

**Mr. LeBlanc:** I haven't spoken to him nor has Mr. Cook spoken to me in months. I couldn't give you an exact date on that, but the last time he spoke to me was to ask me if he should convene a meeting of the committee. He did that many times and I agreed with him. Many times I furnished agenda items for the meetings, but the meetings never came about. So, I haven't spoken to him in months.

**Mr. Grande:** Thank you. A question to the minister. Mr. Minister, in view of this letter from the Premier to you, would it be fair to say that the movement of Welcome House from its present location to the University-Dundas location that you said had been going on for a long time with no action taken—or, as you put it, discussion was going on, in order to effect a decision—would it be fair to say—you have more intimate knowledge, obviously—that Lorne Henderson, the Minister of Government Services, did not want to do that?

**Hon. Mr. Baetz:** Didn't want to have the move take place?

**Mr. Grande:** Not necessarily did not want to move, but did not want to provide that building for this particular service.

**Hon. Mr. Baetz:** I don't know what Lorne Henderson's long term stance to that was. Maybe he had some reservations, I don't know. I didn't talk to him about it. By the time that I got to talk to him, it—

**Mr. Sweeney:** It was the Premier's decision.

**Hon. Mr. Baetz:** Well, it may have been. I think, when the Premier suggested to the ministers that they co-operate, that's a fair message.

**Mr. Grande:** That's a tall order. That's what it is, a tall order.



**Hon. Mr. Baetz:** I think it's a reasonable order, too. Why not?

**Mr. Grande:** I think Mr. Sweeney quoted that particular section that I was going to quote as a result of my question. That's quite all right, it's there. It appears to me that Lorne Henderson did not want to move or did not want to move—

**Hon. Mr. Baetz:** I didn't say that.

**Mr. Grande:** I'm making that—

**Hon. Mr. Baetz:** You're making that accusation.

**Mr. Grande:** Yes.

**Hon. Mr. Baetz:** Okay.

**Mr. Grande:** On February 27, all of a sudden, the order came from the Premier and then Lorne Henderson and his deputy, John Thatcher, co-operated in every way possible.

**Hon. Mr. Baetz:** I would think, Mr. Chairman, that Lorne Henderson, who was responsible for these buildings, realized this building was empty at the time, or was about to become empty, and as Minister of Government Services he would welcome the opportunity to see one of the buildings put to good use. I have seen nothing to make me think that Lorne Henderson was opposed to this idea, ever.

**Mr. Grande:** We will continue with this, obviously. For my purpose I have no further questions, Mr. Chairman.

**Mr. Chairman:** Thank you very much, Mr. Grande. Do you have any further comments, Mr. LeBlanc?

**Mr. LeBlanc:** No, thank you, Mr. Chairman.

**Mr. Chairman:** Do you have any further comments, Mr. Minister?

**Hon. Mr. Baetz:** No, except, as I said at the outset, I regret that we didn't discuss some of these things when Mr. LeBlanc was still with the ministry, because I do think it's an important matter to consider—

**Mr. Grande:** If he had you'd have fired him.

**Hon. Mr. Baetz:** You said that, I didn't. I think that's an insulting remark to make, and I shall take it as that.

**Mr. Grande:** It's a political remark.

**Hon. Mr. Baetz:** Indeed it is.

**Mr. Chairman:** Mr. LeBlanc, I want to thank you on behalf of the committee for being here this afternoon and making yourself available. We thank you and we're grateful to you. Thank you very much.

**Mr. LeBlanc:** Thank you.

**Mr. Chairman:** The committee will now adjourn to reconvene tomorrow afternoon. Mr. Grande will then complete his comments and the minister will respond to the opposition critics. Then I presume we will be dealing with some of the cultural organizations and institutions.

**Hon. Mr. Baetz:** Yes. Do you want them all here tomorrow?

**Mr. Grande:** Mr. Chairman, my understanding was we would have Mr. Philippe LeBlanc and then we were going to have some comments regarding this particular vote. We're not bypassing this vote?

**Mr. Chairman:** No, not at all.

**Mr. Grande:** That's fine.

**Hon. Mr. Baetz:** Mr. Chairman, I assume all of this was for Mr. LeBlanc, it wasn't part of the estimates.

**Mr. Chairman:** Yes, it is part of the estimates.

The committee adjourned at 6:30 p.m.

## CONTENTS

---

Tuesday, April 10, 1979

Citizenship and multicultural support program .....	S-30
Adjournment .....	S-57

## SPEAKERS IN THIS ISSUE

---

Baetz, Hon. R. C.; Minister of Culture and Recreation (Ottawa West PC)  
 Blundy, P. (Sarnia L)  
 Breaugh, M. (Oshawa NDP)  
 Conway, S. (Renfrew North L)  
 Gaunt, M.; Chairman (Huron-Bruce L)  
 Gigantes, E. (Carleton East NDP)  
 Grande, A. (Oakwood NDP)  
 Gregory, M. E. C. (Mississauga East PC)  
 Kennedy, R. D. (Mississauga South PC)  
 Lawlor, P. D. (Lakeshore NDP)  
 Leluk, N. G. (York West PC)  
 McClellan, R. (Bellwoods NDP)  
 O'Neil, H. (Quinte L)  
 Sweeney, J. (Kitchener-Wilmot L)  
 Welch, Hon. R.; Provincial Secretary for Justice; Deputy Premier (Brock PC)  
 Wildman, B. (Algoma NDP)

**Witness:**

LeBlanc, P., Former Director, Multicultural Development Branch,  
 Ministry of Culture and Recreation

**From the Ministry of Culture and Recreation:**

Forster, J. F., Communications Officer  
 McPhee, R., Executive Director, Citizenship Division  
 Wright, Dr. D. T., Deputy Minister







212  
77



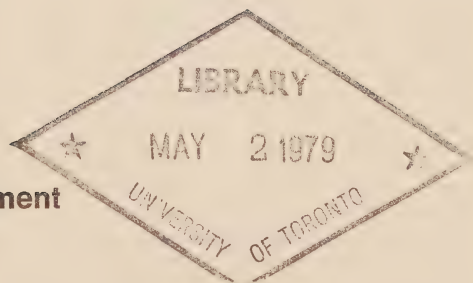
No. S-3

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Estimates, Ministry of Culture and Recreation



**Third Session, 31st Parliament**

Wednesday, April 11, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.



# LEGISLATURE OF ONTARIO

WEDNESDAY, APRIL 11, 1979

The committee met at 2:06 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

**Mr. Vice-Chairman:** I see a quorum.

Committee members, our first order of business is to deal with substitutions here today and we have Mr. Lawlor still substituting for Ms. Gigantes, Mr. Conway for Mr. O'Neil, Mr. Turner for Mr. Ramsay, and Mr. Eakins for Mr. Sweeney. They are all here in attendance.

**Clerk of the Committee:** Mr. Sargent, are you substituting for Mr. Gaunt?

**Mr. Sargent:** Well, the whip said I should be here.

**Mr. Vice-Chairman:** He could substitute for Mr. Gaunt. You are Mr. Gaunt.

**Mr. Sargent:** Okay. How much do I get?

**Mr. Vice-Chairman:** The first order of business today—I am in my place and properly so. I am also vice-chairman of this committee.

We have deferred from yesterday a motion put by Mr. Lawlor, and if I may read it we will deal with the motion:

Mr. Lawlor moved that at the next sitting of the House this committee present an interim report and recommend the adoption of the following:

Whereas this committee will be reviewing the decision to close Lakeshore Psychiatric Hospital by September 1, 1979; and whereas the current transfer of patients and closure of the special observation unit seriously impair the hospital's ability to deliver psychiatric services to the local community; therefore, all patient transfers should cease forthwith and special observation units should be reconstituted immediately at the hospital pending the final report of this committee's deliberations.

That motion is before us and I would like your direction.

**Mr. Leluk:** Mr. Chairman, I would like to speak to the motion if I may.

**Mr. Vice-Chairman:** Yes.

**Mr. Leluk:** I would like to point out to the committee some facts that were given to me. The director of the special observations unit,

Dr. Franks, is retiring on June 30, and even if the hospital were to continue I understand that the psychiatric hospitals branch has advised that the unit would not necessarily be continued in its present form.

The Lieutenant Governor's warrant patients now do come under control of the Queen Street Mental Health Centre as of April 15, but are, I understand, going to remain at the Lakeshore Psychiatric Hospital until the wards they are presently in are moved. There are no transfers planned until at least May 15, and I was advised that a meeting took place last night with the Minister of Health, Mr. Timbrell, and representatives of the Ontario Public Services Employees' Union—I believe Mr. Sean O'Flynn and Mr. Sam Wood were among those present—and that they were assured there would be no transfers until May 15.

Therefore, Mr. Chairman, I feel the motion is redundant and I would urge the members of the committee to vote against it.

**Mr. Lawlor:** Mr. Chairman, all the more reason, therefore, why the Conservative members might very well accede to the motion; they have nothing to fear. I was hoping there would be a little more in the motion and that it would cause a certain consternation, at least in the mind of the minister; he needs it.

The motion reads: "Pending the final report of this committee's deliberations"—this committee will deliberate, I would think at the most, for two weeks. There is an allocation of days—maybe five, maybe six sitting times—we will hear the delegations; and this committee will reach its determination long before what Mr. Leluk says the critical date will be. Therefore there is no point in your being obtuse about it or raising objections. I am surprised at the statement. I thought they would resist ab initio and all the way through. But that is not even necessary any longer.

My information is that this special observation unit, on Mr. Leluk's own statement, will be retained with respect to the allocation. They have to have someone at the hospital to allocate the new patients as they come into the building and to assess them, to find out the degree of the illness and the proper treatment to be accorded to these people. That in the recent past has been dissolved.

Maybe there have been some second thoughts. As I said yesterday, the minister and, I believe, the deputy or Mr. Juppe who is in charge of all this, were absent at the time. Lower members of the echelon took this critical decision and said, "I think I'll go this far." Internally, in the ministry, there was a great deal of dislocation caused by it. But the minister hasn't got the gumption to pull back on these things. He would increase his stature, and might even become Premier eventually, if he would admit somewhere along the way that he might just possibly be wrong on a few decisions, or that at least his staff was.

But he won't do that. He is young and he is foolish and he is wet behind the ears—

**Mr. Vice-Chairman:** Order.

**Mr. Lawlor:** With those thoughts, I would ask the members of the committee, since no misadventure will apparently take place, to affirm this decision. It would show this committee has some gumption and some teeth, and that it exists for something besides giving a blueprint to obtuse ministers.

**Mr. Leluk:** In my earlier statement, I neglected to mention that the special observation unit is no longer in operation. Those patients from that unit have been moved to wards three and four within the hospital facility and are being looked after there.

I want also to point out that the patients are assessed on admission; they are not assessed in that particular unit. The assurances have been given by the ministry there would be no transfers until May 15. I just want to point that out again.

**Mr. Lawlor:** That sheds another light. I assumed a different state of affairs from what you said earlier.

**Mr. Leluk:** I'm glad you have seen the light, Patrick.

**Mr. Lawlor:** I assumed that it has been dissolved and the dissolution therefore continues. All I am saying to this committee, therefore, is that in my information that is a retrograde move.

People sent on Lieutenant Governor's warrants, and even by allocation by doctors, to the special observation unit, are dangerous people. Or they can be dangerous, either to themselves or others. They are referred in some instances by the courts because they are unfit to stand trial. The judge has said, "Your degree of mental disability is such that we can't say you know the full intent and meaning of your acts."

Now what is he saying? He is saying they are going to be allocated to wards three and

four, mixed in with the general population of the hospital, with all that implies.

Don't bow your head before the ministry—I am not prepared to—and say, "They know best." The fact of the matter is, I don't think they do. We have much too much faith in big government and the goings-on behind the scenes. They explain nothing to anyone; they just blunder ahead, and we like sheep say, "They must be right, or they wouldn't do it." That's just nonsense.

[2:15]

I have a case in point where a young woman, suicidal, was placed in that observation unit which was closed. She immediately walked out of the hospital because at that stage she was with the general population and could move freely and it was hard to look after her. Her parents were phoning our offices, desperate, first of all, to learn where she was—no one knew—and secondly, because of the harm she could do to herself in no longer having any supervision.

That is the kind of thing that has eventuated. I think we should tell the minister to put that back in place. If it is up to May 15, so be it. By that time this committee will have long finished its task.

**Mr. Conway:** Mr. Lawlor unfortunately reduced his constituency somewhat by his totally unprovoked attack on the young and the foolish.

**Mr. Lawlor:** I didn't mean you, Sean.

**Mr. Conway:** I very much appreciate Mr. Leluk's points of information, having been here yesterday and heard Mr. Lawlor's reasons for the motion. My caucus is very concerned that no transfers occur until this committee has had the opportunity not only to review the Lakeshore matter but to report on it.

Speaking on behalf of the Liberal members of the committee at this time, I want to indicate that I do accept the assurance that no transfers of any kind will be effected before May 15. I think that does give us ample opportunity to review the situation at Lakeshore. For that reason I have recommended to my colleagues the motion is, to that degree, redundant or inappropriate. If it is not withdrawn then I would recommend voting against it.

**Mr. Kennedy:** Mr. Leluk in his second comments mentioned that the unit is now closed and those patients are in other wards. So it is dealt with.

Motion negated.



**Mr. Lawlor:** You are losing a splendid opportunity to put them on the spot.

**Mr. Kennedy:** You are the one on the spot.

**Mr. Conway:** Before we move to the estimates of Culture and Recreation, Mr. Breaugh made the point yesterday, and I think it is a very good one, about a steering committee to deal with some of the administrative problems regarding preparing for the special reference on Lakeshore. I am wondering whether Mr. Lawlor has any comments in that connection, since he was nominated unofficially yesterday as the representative of the New Democratic Party. I just want to indicate my willingness to meet as early as possible to set in motion those sort of mechanical things that will be required to deal with witnesses and engage in such advertising as is deemed appropriate.

**Mr. Lawlor:** I am extremely cautious these days as to with whom I consort. Who is on that committee, Sean?

**Mr. Conway:** It is not yet determined but it was suggested yesterday that perhaps Mr. Lawlor, Mr. Kennedy and myself would constitute it, if that was agreeable.

**Mr. Lawlor:** I have doubts about Kennedy, but I will go.

**Mr. Conway:** If it is generally agreed to, then perhaps I could move a motion that steering committee be empowered to exist and meet to establish such items as they consider necessary for dealing with the Lakeshore reference.

**Mr. Vice-Chairman:** I will accept that as a motion to establish a steering committee. Do you want to name the members today? The committee would consist of Mr. Kennedy, Mr. Lawlor and Mr. Conway.

Motion agreed to.

#### ESTIMATES, MINISTRY OF CULTURE AND RECREATION (continued)

**Mr. Vice-Chairman:** The next order of business is to get under way with the Culture and Recreation votes. Under vote 3002, item 2, the first order is the Royal Ontario Museum.

**Mr. Grande:** Mr. Chairman, on a point of order: I understood, since my leadoff remarks were not completed, that I would be given the opportunity to complete them. It is customary for the critics to end their leadoffs; then the minister responds; and then we go to vote for vote.

**Mr. Vice-Chairman:** I'm here at the pleasure of the committee. I was only given instructions that members of these various

groups could avail themselves of the time today and would be hard pressed to make other arrangements. We were trying to hear them before we went on at length about those remarks. Now, I am prepared to take direction from the committee as it relates to that request of the chair. They're here and I'm in your hands.

**Mr. Grande:** Mr. Chairman, may I suggest that, in the normal course of events, in terms of our estimates, we do proceed at least with a Liberal critic in this particular case and with the critic for the New Democratic Party. The minister responds to the leadoff remarks and then we go on to the votes.

**Mr. Vice-Chairman:** The minister was prepared to wait. I thought we had agreed. I can't make a determination.

**Mr. Grande:** Mr. Chairman, may I point to you what the chairman said on Monday: that is, that I would be first, in terms of completing my leadoff remarks on Wednesday, because yesterday we had Mr. LeBlanc before us. So I proceeded along those lines.

**Mr. McClellan:** It is normal courtesy to both critics and the minister to continue the sequence. The normal sequence with estimates is to complete the leadoff remarks, then have the ministerial response and then get into the—

**Mr. Vice-Chairman:** Mr. McClellan, do you understand the direction that was given me today?

**Mr. McClellan:** Well, I understand the direction that was—

**Mr. Vice-Chairman:** The committee had agreed to do it in this fashion. Now, as I said, I'm here to be directed by you. I'm only trying to carry on in the way it was set up on the schedule. If you want to go back and have Mr. Grande make his submission, I imagine that would be in order. But we were asked if we would digress from that in order to hear those people we would like to convenience today.

**Mr. McClellan:** We may have a difference of understanding—

**Mr. Vice-Chairman:** I thought we had agreed on it—

**Mr. McClellan:** —around what the agreement was. My understanding was that the leadoffs would continue and finish today and then we would get into the business. I mean, yesterday's proceedings were under unusual circumstances which deviated from the normal procedure on estimates debates, but I would like us to continue with the normal procedure, finish the leadoff responses and—



**Mr. Vice-Chairman:** Were you not here when they made the agreement?

**Mr. McClellan:** Yes, I was.

**Mr. Vice-Chairman:** Was that not the agreement?

**Mr. McClellan:** I am stating my understanding of the agreement.

**Mr. Vice-Chairman:** That we would continue with Mr. Grande—that's your understanding? Is there anyone else who would like to speak to this point?

**Mr. Jones:** I would like to say that I would certainly be in favour of us sticking with the agenda. We have already, over the last couple of days, been digressing and digressing. Now, maybe Mr. Grande would just say how long he expects to take for his wrap-up or summation. Can you make a guess on that?

**Mr. Grande:** Mr. Vice-Chairman, I really resent those comments. If the critics of the two parties intend to take all the time in the world for their leadoffs and the minister responds, so be it. I'm not prepared to say whether I'm going to take 15 minutes or 20 minutes.

**Mr. Vice-Chairman:** This is going a little afield. I think we understand the situation. I just want other comments from those who were here and heard the arrangement, and then we'll put it to the vote, if we have to. Anyone else who would like to—

**Mr. Kennedy:** I wasn't here.

**Mr. McClellan:** Who is inconvenienced today, if we don't hear them? Is there anyone here now for whom a later appearance would be a great expense or inconvenience?

**Mr. Vice-Chairman:** The list reads: The Royal Ontario Museum; the Ontario Heritage Foundation; the Art Gallery of Ontario; McMichael Canadian Collection, the Royal Botanical Gardens; CJRT Corporation; Ontario Arts Council. This is the order up to Mr. Grande's opening remarks. Now, would you want to consider hearing some of those who are not based in Toronto and would have to come back? Mr. Lawlor?

**Mr. Lawlor:** I was here most of the day, and I understood the delegations were coming on; but I think the only fair thing is to permit—I am sure Mr. Grande hasn't got a great deal more; I think it is wrong to ask him precisely how much—

**Mr. Vice-Chairman:** He wouldn't share that thought with us.

**Mr. Lawlor:** Let him finish that off; I am sure the minister can reply incisively in his

usual fashion, and we can get on to these delegations.

**Mr. Vice-Chairman:** Thank you, Mr. Lawlor. I will not continue this debate any longer. If we can't accommodate the people who are here, let us carry on with Mr. Grande.

**Mr. Grande:** Mr. Chairman, on Monday, when six o'clock rolled along, I was talking about the innovative program that the ministry instituted last year, namely, the Half-Back program.

At that particular time I was in the midst of commenting that the minister and the ministry staff seem to be indicating that, as far as the ministry is concerned, the program was very successful.

I was also beginning to give some reasons that the program indeed was not successful; as a matter of fact, the program was a total disaster.

One of the reasons it was a total disaster is that, as far as I am concerned, the program was established for two particular purposes. One was to sell more Wintario tickets, and the other one was to increase the visibility of the ministry and the minister. I guess over the past days we have heard quite a bit about the increasing visibility.

Let me give you some reasons. The first is that the ministry accepts the fact that in 90 per cent of the households in the province somebody in each household buys Wintario tickets. However, the participation in the Half-Back program was only nine per cent.

The ministry projected that 3,000,000 tickets would be redeemed at a cost of \$1,500,000. However, only 1,200,000 tickets were redeemed at a cost of \$600,000.

The ministry had estimated that 1,000,000 Canadian-authored books and subscriptions to magazines would be bought by the public. Instead, only 335,000 Canadian books and magazines were bought by the public.

If the ministry calls that a success, I really doubt it very much.

As I indicated earlier, the only success the minister had was that the visibility in the province was high; around 70 per cent of the people were aware of that program. If this is the only success that the ministry had, if this is the only reason the ministry wants to continue with the Half-Back program and to go into films, into buying records and into sport activities, purely and simply for its visibility for (a) Wintario and (b) the ministry and the minister, that is the ministry's business.

All I'm pointing out is that the program was not successful, despite the report on the evaluation of the program which seems to imply otherwise.

I want to go into Wintario briefly. Even though I understand why the Wintario money is being dispersed throughout the ministry—there is a line vote in each division and branch of the ministry—none the less I would like to express my deep concern that in a matter of two or three years what we might be able to see, and perhaps what we will see, is that Wintario moneys are going to be substituted for the tax money this ministry ought to have in order to function. I'm very concerned about that move.

[2:30]

I'm just putting the minister and the ministry on notice that I will be taking a very close look in terms of how that Wintario money is being dispersed and whether it is going to be substituted for money the ministry ought to have for its program from a tax base.

My next concern regarding Wintario is the freeze on capital construction and capital applications the ministry effected in November of last year. The reason the ministry said it needed to do this was that it wanted to find out what kind of facilities it had around the province in order not to duplicate them. As soon as I heard that I thought, "Wow, what a fantastic step! This is socialist planning at its best." However, socialist planning coming from a Tory government really sets me back and then I begin to look a little more deeply into the situation to find out why this is taking place.

The freeze did not come in November, as the minister pointed out in his remarks in the Legislature. The freeze came on August 1, 1978. There are letters on file that indicate that as early as August 1 Wintario criteria for capital construction had been changed. I have information from the YMCA and from other people around this province who say, "We're trying to put in a Wintario capital application, but the field people within the ministry are telling us to hold off and not to do it because the criteria are in the midst of a change."

The net effect of that is the many people who would have put in their application held back and did not do so. In effect, as far as I'm concerned, you have in the ministry for capital construction purposes approximately \$40,000,000 to \$45,000,000 that has not been spent and that has accumulated out of the Wintario profits from August 1 right up to the present time.

I would like to know what the ministry is doing with that money, what is happening to the interest on that money and is the minister or the ministry thinking in terms of developing a Wintario trust fund, as has been suggested to him by the CLOUT committee or the arts community? Are you thinking in that direction?

Mr. Chairman, since you have been the Liberal critic for Culture and Recreation, you know my concern about the money that is going, has gone and will continue to go, I guess, to the private clubs in this province. You will recall that at one particular time the former minister produced a memorandum in the Legislature saying, "These are the six Wintario principles, which are going to be respected. Private clubs that get any money from this ministry through Wintario are going to have to sit down with us and draft a letter of understanding that these conditions are going to be met; namely, the condition of public accessibility to those particular facilities."

As a matter of fact, the former minister said, "We're going to be very tough with these clubs. We're going to take them to court if they do not use the funds for the purposes for which they requested them and if we're not satisfied that the conditions in the letter of agreement are being met."

In the past years I haven't been able to do very much in terms of finding out what really has taken place. However, this year a letter came across my desk. It happens to be about moneys which were sent to a private club which, by the way, ironically opened up the whole field in terms of Wintario money going to private clubs. It is the Ashbridge's Bay Yacht Club.

I would like to read the letter I have which was signed by the former deputy minister, R. D. Johnston. It was sent to the chairman of the ways and means committee of the Ashbridge's Bay Yacht Club. In here we will find whether those particular six Wintario principles and the letter of agreement which was signed between the ministry and the club, have been upheld. Let me read it. The date of the letter is January 24, 1979, and it is from the ministry to the Ashbridge's Bay Yacht Club:

"The amount that was requested at that time to complete the total Wintario assistance was \$55,130.55. As you may be aware, the issue of this final payment has been delayed for the following reason:

"Our ministry representative had expressed some concern with regard to the club's willingness and ability to provide the level of



public accessibility which had been requested at the time of the original approval.

"I know that he has more recently met with members of your Wintario committee and indicated to you his concerns, suggesting a set of guidelines for committee responsibility and for the operation of club facilities in connection with promoting public participation for recreation purposes. I would emphasize his comments and insist that the club comply with his requirements within the next two weeks."

Then comes the paragraph:

"I appreciate that the club may be experiencing some financial constraint because of the withholding of this last payment of the Wintario grant, and under those circumstances I have approved its issue. A cheque will be forwarded as soon as possible."

The club has been told by the ministry, "You are not fulfilling the conditions under which you received the grant in the first place. You received the first two instalments." I am not sure of this fact, but probably the grant was in the vicinity of between \$140,000 and \$150,000. It will now receive the last instalment. The club has still not fulfilled the particular responsibility of providing access to the public, it has still not fulfilled the conditions that the ministry requested of the club and the club and the ministry had attached their signatures respectively on that document; yet the \$55,000 is sent out to this club without it having fulfilled these conditions.

This is what I feared from the very beginning when the movement to support and provide Wintario money to the private clubs in this province came about. I have stated my concerns, but it wasn't until this particular time that I had information on the principles which the ministry and the club had accepted, yet the ministry provided the money without the club having done anything, or very little, in terms of providing for public accessibility.

I have stated it before and I will state again, any private club in this province that gets money from Wintario, which is public money, should have total public accessibility as far as I am concerned. The door should be open.

I am not one to say if the ministry provides 20 per cent of the funding that public accessibility should be only 20 per cent of the time. If the club wants public money, then the club must open its doors to the public and to the participation of the public.

I don't want to go on for a long time in my leadoff remarks, however, Mr. Chairman, I thought that this committee, the ministry

and the minister should be aware that, these kinds of things are happening. The kinds of things we found out about yesterday and the kinds of things I am showing proof to you as happening today should not be going on in this ministry.

If the ministry wants to create programs to increase the visibility in the eyes of the public, that is fine—provided it produces programs that are sensitive to and fulfil the needs of the people in the province. I am not at all concerned with the ministry only being all show and no substance. With that, Mr. Chairman, I will end my leadoff remarks.

**Mr. Vice-Chairman:** The next order would be to have the minister's response to the opening remarks, or I would be directed by what you would like to do, Mr. Minister.

**Hon. Mr. Baetz:** Mr. Chairman and members of the committee, in deference to the people who have been invited to come here, and recognizing the tight schedule under which several of them are operating—I know they have to get back, especially the people from the Royal Ontario Museum people and the Ontario Educational Communications Authority—with your permission, Mr. Chairman and members of the committee, I would like to defer my comments on the opening statements made two days ago by the member for Quinte (Mr. O'Neil) and today by the member for Oakwood. If you would allow me to do that, I would like to make my response after we have heard from the agencies which have been invited here.

**Mr. McClellan:** Let's be clear what we are doing here. This is an estimates debate; it is not an opportunity for the minister to provide a forum for those for whom he wishes to provide a forum. There may be individual institutions that members of the committee will have questions of, and I assume that members of the committee will indicate which institutions they want to have discussed and with respect to what topics.

Reading from yesterday's Hansard, from the very last page, I quote the chairman, Murray Gaunt:

"The committee is adjourned to reconvene tomorrow afternoon. Mr. Grande will complete his comments, and the minister will respond to the opposition critics. Then I presume we will be dealing with some of the cultural organizations and institutions."

We have set aside this afternoon for the cultural organizations and institutions; we understand that they are here today and we appreciate their attendance. As we wish to question them or discuss their programs, we will. We also understand that they are not



able to be here for every day of the estimates. But personally, just speaking as an individual, I would like to proceed with the instruction we received from the chairman yesterday: to have the minister's response and then to get into the business as we had ordered it.

**Mr. Vice-Chairman:** I am here to take direction from the committee.

**Mr. Minister,** do you have any other comment on this?

**Hon. Mr. Baetz:** Yes, simply as a point of information to guide the committee: We had a rather long introductory statement by the member for Quinte in which he made a number of what I think are very serious accusations, and I am prepared to respond to those in some detail. I also wish to respond to some of the points made by the member for Oakwood which I found totally incorrect. That will take some time; it will take me at least an hour. It was for that reason, frankly, that I felt if the committee has any questions to direct to any of the agencies assembled, this would be the time to do it. I feel it would be unfair for me simply to reply in three minutes' time, knowing there are a lot of people here who, if the committee wishes to ask questions of them—

**An hon. member:** If they want to excuse them—

**Hon. Mr. Baetz:** If the committee wishes to excuse them all, fine. We thought we were accommodating the committee, frankly.

[2:45]

**Mr. Lawlor:** If it means that the minister is likely to truncate his remarks and fore-shorten them, then that's a real consideration. I would trust that would not take place. The normal procedure in these committees is that numerous representatives of the various groups and agencies do appear and we're always grateful to have them here. I'm usually in the justice committee and we have large numbers from the staff of the Attorney General, men who are extremely busy, the courts being in the mess they are, being required on the spot and in their own tasks and jobs.

If I may put it this way, I wonder if the minister could make a somewhat better case for the delay? We are departing from the accepted, normal and long-held procedures. I don't worship tradition, but I have a kind of nudging liking for it. To depart from tradition without damn good reasons seems to me to be a mistake. If the minister can make a better case, all right; I'm inclined to listen.

**Mr. McClellan:** It's not a question of departing from tradition; it's a question of departing from the standing orders, which are absolutely clear.

**Ms. Gigantes:** And which are set up for good reason.

**Mr. Vice-Chairman:** I only stepped in, as I suggested to you before, at the direction of the committee. We have subsequently been given the record, and the record is quite clear. I thought the committee might still be willing, if it were to help the proceedings, to hear someone who might have to come from further afield. We don't want to drag this discussion out. I would suggest, Mr. Minister, that if you have any comments we will carry on.

**Hon. Mr. Baetz:** You want me to carry on with my comments?

**Mr. Vice-Chairman:** Yes. I think we will resume the order we've been given. Would you go on with your comments, Mr. Minister?

**Hon. Mr. Baetz:** I'll try to truncate as much as I can, but I assure you it will be difficult. I will probably not be able to shorten it.

The member for Quinte indicated that he was still very new in his portfolio as the critic of Culture and Recreation. It was obvious from some of the comments he made that he was indeed very new, and also that he had not received proper information from whoever helped him prepare his statement.

In his opening remarks the member for Quinte raised the issue of the offensive articles that appeared in the Toronto police publication and wondered why we had not taken any action on that. As I pointed out in my opening statement, the work of my ministry in multiculturalism is preventive, rather than therapeutic. The concern of the government over this incident has been well exemplified by the statement issued, not by my ministry but by the Ontario Human Rights Commission two weeks ago. I have here a copy of the news release issued by the Ontario Human Rights Commission which I am prepared to leave with the committee members.

The member for Quinte also stated, or certainly implied, that we had lost public money because of the actions of the Kensington Art Association. On the issue concerning the Kensington Art Association and my ministry's grant to that organization, the facts are, as you may recall, that I responded to Mr. Kerrio's question of December 13, 1978, in the House concerning this matter. I will again table the response given at that time, as well as provide you with the following additional information. Since my statement to the House

I would like to report that, through the enforcement of the ministry's agreement, the Kensington Art Association had the option of immediately repaying the grant or reinvesting it in a similar space.

On March 9, the ministry was advised by their solicitors that a property at 124 Lisgar Street was acquired and the proceeds from the sale of the property was reinvested in this acquisition. The ministry is now investigating the nature of the program to ensure that its use is in accordance with the original agreement. But certainly there is not a doubt in the world that we have not "lost" that money, through negligence or violation of the agreement or anything else.

The Liberal Party critic also raised the issue of the current status of the Athletics Control Act. This piece of legislation has been under review by the minister for some time. He seemed to think that there were, in fact, two athletic commissioners for Ontario. I can assure you, Mr. Chairman, and members of the committee, that is not the case.

It is true that we have had in my ministry an athletics commissioner for Ontario who has concerned himself primarily with professional boxing and wrestling. As a result of some discussion over some period of time with the Ministry of Consumer and Commercial Relations, we have agreed that the athletic commissioner and the administration of the Athletics Control Act should be transferred from my ministry to the Ministry of Consumer and Commercial Relations, because that largely deals with the licensing and the control of professional sport. It does not relate to promotion and assistance given to amateur sport.

So, there are not two athletic commissioners in Ontario, there is one. The new one will be Mr. Jim Vipond, as was reported in the Globe and Mail some weeks ago. He is taking office on April 15. Mr. Ray Wittenberg, who I think was mentioned and who is in my ministry, will assume other duties in my ministry. We, of course, are going to continue all our work and responsibility in the amateur sports field, whereas the licensing and control of professional athletics will go to the Ministry of Consumer and Commercial Relations.

In response to the honourable member's question concerning the Frankfurt Public Library and its Wintario grant, I would like to offer the following:

The processing of this grant for payment was held up from December 11, 1977, the date of receipt of application, until March

1979 because the library board had not submitted a satisfactory report on the previous grant, as is required by ministry policy and our auditors. So the delay occurred. Several unsuccessful attempts were made to obtain a satisfactory report, hence the delay in dealing with the subsequent grant application.

I think there may be the occasional human error but generally where there are delays in making payments there have been good and sound reasons.

Concerning the statement of the Liberal critic that the ministry relies on statistics from the United States in the arts and cultural development research field, I can assure him that neither the ministry nor I rely on US sources of information or research which may not be relevant to Canadian needs. It is true that there have been some interesting US statistics on arts attendance and funding, but the ministry by no means relies only on these studies. A number of studies have already been commissioned by the ministry, by the Ontario Arts Council, by Statistics Canada, the Council for Business and the Arts in Canada, the Canadian Conference of the Arts, and so forth.

Another item of concern raised on Monday was the need for co-ordinating our activities with the federal government, other provinces and municipalities to prevent overlapping in services and funding. This issue, one of delineation of responsibility, was discussed at a recent interprovincial and federal-provincial meeting of ministers responsible for sports, fitness and recreation. There was agreement at this meeting that improved consultation and co-ordination was needed between governments.

I do agree very much with the Liberal critic that at the ministerial level or policy level there's a great deal of uncertainty about who is responsible for exactly what. Mr. Chairman, I would like to assure this committee that, regardless of the outcome of the federal election, it will be my intention to meet at a very early date with the Secretary of State to try to develop some overall plan and overall understanding for the support of arts, culture and sports as between the federal government and the provincial government. I would not for one moment try to defend the present situation. I realize that a good deal still needs to be done.

This in no way overlooks the constant, through perhaps not daily, liaison that does go on among many of our agencies operating in Ontario, for example, the Ontario Arts Council and the Canada Council. These kinds of negotiations are going on constantly, but I



think what we do lack is some kind of overall plan and some kind of overall understanding as to what is the federal responsibility and what is the provincial responsibility in terms of financing and supporting the cultural, arts and sports agencies.

Now I am going to truncate, Mr. Lawlor. The member for Quinte was also concerned about the activities of the fitness program with regard to the fitness level of children, plus the general fitness of Ontarians. The Ministry of Education, with the co-operation of the Ministry of Culture and Recreation, has recently published Curriculum Ideas for Teachers on Fitness Programming for Primary and Junior Grades. The ministry has also conducted surveys and analyses of program participation and conducts follow-up studies to measure the effectiveness of its fitness program.

The member for Quinte also raised his concerns about the mandate and the activities of the Ontario Hockey Council. Here again I will condense. The essence of the member's concern was that whereas we have the Ontario Hockey Council which is part of my ministry, we seem to have undertaken this major study of violence and other related matters in amateur hockey in Ontario through another agency.

That is not correct. It is the Ontario Hockey Council, which was established partially in response to William McMurtry's report on violence in hockey, that has been asked by my ministry and has received the necessary financial support to carry out this rather gigantic survey of some 90,000 families who have children in amateur hockey.

I have a few quick comments in response to Mr. Grande's opening remarks. He referred to the federal government's immigrant settlement and adaption program. I feel that Mr. Grande has confused two distinct issues. He did not distinguish, firstly between which activities or projects are eligible for funding—that is, what is fundable—and, secondly, how long the funding continues.

I will start with what is fundable. Under the federal government's ISAP purchase of service program, agencies are refunded for the direct services they provide to immigrants who have been resident in Canada for less than three years. Here Mr. Grande is out of date when he says the cutoff is two years. Between 1977 and 1978, ISAP did expand its formula from two to three years.

The point at issue is the lack of funding for direct services to immigrants who have been resident in Canada for more than three years. The provincial government supported a formula under which agencies could have claim-

ed up to one third of the client load, irrespective of length of residence. Unfortunately, the federal government did not agree with this proposal. However, I am hopeful that we can negotiate an arrangement to cover this ISAP gap.

Mr. Grande: In response to the core funding. That's what I would like to hear.

Hon. Mr. Baetz: Mr. Grande also claimed that the provincial cabinet turned down an application for an increased budget for the ministry's newcomer integration grants program. His claims are erroneous. When it looked as if the province would receive enriched funding from the federal government under the proposed block funding for social services, I planned to ask for a significant increase in order to fund direct services to immigrants with more than three years' residence. But the federal government cancelled the block funding proposal, so my request was withdrawn.

Rather than being an apologist for the federal government, I would like to respond to some of the points Mr. Grande made about the ministry's newcomer program. It is true that under the existing criteria for the newcomer integration grants program, projects are funded up to a three-year limit. This is because the program was originally intended to fund innovative short-term projects. And, in this regard, it has been very successful.

Mr. McClellan: Who's going to give core funding?

Hon. Mr. Baetz: Also, while the grants cover administrative costs related to eligible projects, they do not provide for agencies' general overhead costs, ie. core funding.

That's what I have in my text. We're on the same wavelength.

Mr. di Santo: Twenty-eight of them are shutting down.

Hon. Mr. Baetz: Let me read the next paragraph; it may offer a little hope.

When I started as minister I met with representatives of several immigrant agencies which raised their concern about the current newcomer integration grants program criteria. While I am committed to these criteria for 1979-80—for this fiscal year—I have responded by appointing an internal policy review committee for this program, which started its work in February of this year. I can just add here that with my background in the volunteer field I know that agencies cannot limp on from year to year, from year to year, getting project funding on a "maybe" basis. I can understand the concerns these agencies have.



However, for this year at least, because nobody has gone beyond the three-year limit, they are assured of financial support from us. Hopefully, in the course of this year we can work out some more permanent arrangement.

**Mr. Grande:** Why are they closing down?

**Hon. Mr. Baetz:** You tell me.

**Mr. Grande:** But you should know.

**Hon. Mr. Baetz:** You tell us which ones are closing down, and we will discuss that.

I made a commitment to consult with the affected agencies. A questionnaire has been designed which will be mailed to them shortly, and consultation meetings are planned as an integral part of the review process.

I think this will be about the last point that I will refer to here. The member for Oakwood also raised the issue that the ministry is watering down its Experience '79 summer employment program. I should like to remind the honourable member that the Experience program is a government-wide program operated across practically all the provincial ministries.

**Mr. Grande:** I thought they got 100 per cent funding.

**Hon. Mr. Baetz:** The one overriding objective of this program is to create summer employment opportunities for Ontario youth. A secondary objective is to provide opportunities for participating ministries to undertake special projects they or the organizations they relate to would not normally undertake.

There has been no cutback on this ministry's Experience program. The overall budget has increased some \$350,000, or nine per cent over last year. The grant calculation formula has been changed, but it has not been reduced. In previous years, no standardization on the rate of grant existed, and the following formulae were used: For those who had a first-year project, they got up to 100 per cent funding. Those who had a project for the second year in a row got up to 66% per cent funding; and those who had applied for the third year got only up to 33% per cent funding.

The change to a subsidy of 75 per cent of the provincial minimum wage, plus an allowance for support cost, reflects the efforts on the part of the ministry to provide an equitable level of support to all community and/or municipal organizations under the ministry's Experience program.

Certainly, the response in terms of grant applications under this program from all community organizations continues to be enthusiastic. We don't see anybody not applying because we are not prepared to give up to 100 per cent—

**Mr. Grande:** They don't come to you. You read it in the ethnic media.

**Hon. Mr. Baetz:** —as the ministry is in receipt of requests for Experience grant funding in amounts that far exceed the amount of available funds.

Concerning Mr. Grande's statement that there is little understanding of the arts community by ministry staff, and that the funding for arts organizations has been reduced, I give you the following response: While provincial funding of the arts has not been able to meet the most wishful expectations of some parts of the arts community, that community on the whole does recognize the quite incredible increase in provincial support over the last years. In fact, some of you people have said too much support. Since 1975-76 there has been a 30 per cent increase in funding of the cultural agencies.

Isn't that right, Mr. Chairman? Some people have criticized this rather remarkable increase.

**Mr. Vice-Chairman:** Right on.

**Hon. Mr. Baetz:** Right on, and we are not mentioning any names at this point; we are just too polite.

**Mr. Vice-Chairman:** And our people started it all.

**Hon. Mr. Baetz:** But there has been a 30 per cent increase in funding since 1975-76. It is also a fact that the ministry did assign a considerable measure of priority to the agency operating grants. This is evidenced by the fact that each of them has been increased in absolute terms above the level of last year's grant, whereas the ministry's own directly administered transfer payments grants programs have collectively been reduced. We have sacrificed our own internal expenditures in order to maintain grants to the agencies.

It should also be noted that each of the cultural agencies has the capability to obtain operating and capital revenues from other sources, such as admission charges, donations, memberships, et cetera. It is the ministry's hope that financial necessity may be the mother of invention in stimulating the agencies to pursue these other avenues more aggressively, so they may become relatively less reliant on government support in the long term.

**Mr. Grande:** Which agencies are you talking about, anyway?

**Hon. Mr. Baetz:** Which agencies? We are talking about ROM, Ontario Arts Council, CJRT, the McMichael Canadian Collection, on and on and on.

**Mr. Grande:** And you mean these agencies are going to be self-sustaining?

Hon. Mr. Baetz: I did not say that.

Mr. Grande: That is what you said, in the long term.

Hon. Mr. Baetz: No, I did not say that. Do you want me to read that again?

Mr. Grande: Read that again.

Hon. Mr. Baetz: "It should also be noted that each of the cultural agencies has the capability to obtain operating and capital revenues from other sources, in addition to ours . . ." It doesn't say that we are expecting them to—

Mr. Grande: Read further; read further.

Hon. Mr. Baetz: ". . . such as admission charges, donations and so on. It is the ministry's hope that financial necessity may be the mother of invention in stimulating the agencies to pursue these other avenues more aggressively, so that they may become relatively less reliant on government support in the long term."

I don't interpret that to mean we expect them to be fully self-supporting. I can't express it any more clearly than that.

Mr. Grande: That's the direction you're going to go, isn't it?

Hon. Mr. Baetz: As I said in my opening statement, never in human history, as far as we know, has art ever been self-supporting. I expect in our highly developed society it won't be either—that the people, the general public through government, has an obligation to help the artists and the agencies.

Mr. McClellan: Why make such fatuous statements then?

Hon. Mr. Baetz: I had to make that statement because I was being charged with cutting them off and saying they are supposed to be self-reliant.

Mr. Grande: It is a 2.5 per cent increase, is it not, this year?

Hon. Mr. Baetz: We will get to that in a minute.

Mr. Grande: All right.

Hon. Mr. Baetz: As for Mr. Grande's statement that the ministry is "too heavy on the recreation side and light on the cultural side," this is simply not true. Do you want me to spell out why it isn't?

Mr. McClellan: No, no.

Hon. Mr. Baetz: Will you take it as read? You believe it, do you?

Mr. McClellan: No, I don't believe it at all, but leave it for a second.

Hon. Mr. Baetz: I see Mr. Lawlor has been replaced. I think when we get into

some more detail on the statistics we can point that out.

Finally, in dealing with Mr. Grande's comments on the Half-Back program, I can only surmise that Mr. Grande has never really understood the program. This poses somewhat of a problem in dealing logically with his concerns. Those are my words.

Mr. Grande: Pictures of Robert Welch on the Half-Back program?

Hon. Mr. Baetz: If he had spoken to any of the industry associations that have been so actively involved in the Half-Back program, he would have received the industry's response to the impact of the program.

Mr. McClellan: That's what they are saying.

Hon. Mr. Baetz: I would suggest you contact the Association of Canadian Publishers, the Canadian Book Publishers' Council, the Book and Periodical Development Council, the Canadian Periodical Publishers' Association, Magazine Canada, the Writers' Union, or individual writers' or publishers' unions and then you will learn first-hand of their enthusiasm for the program and for what it achieves.

Mr. Grande: Thanks for small mercies.

Hon. Mr. Baetz: I would like to explain that Half-Back is a public promotion program for Canadian artists, writers, performers and musicians, to build awareness of Canadian talent. That is the new Half-Back program, dealing with films and recordings.

Mr. Grande: Let's talk about the success rate; that is what you should talk about.

Hon. Mr. Baetz: We can't talk about the success rate of the new program, because it isn't going to start until May.

Mr. Grande: No, no, no. Of the Half-Back program regarding Canadian-authored books; that is what I want you to talk about.

Hon. Mr. Baetz: I think you were referring earlier—you used the figure 350,000. Was that the figure you used?

Mr. Grande: Three hundred and fifty-five thousand.

Hon. Mr. Baetz: You said there were only 350,000 Canadian books and magazines sold and that is of no consequence. As I said, I would suggest you go to the people in the industry and ask them if that didn't have a very substantial impact on their industry. It was not intended to be a long-term program, it was short-term. It more than achieved what it set out to do.

Mr. Grande: Will you deal with this in a serious way instead of off the cuff? Where is your prepared statement?



**Hon. Mr. Baetz:** I think you have received the report, at least it was supposed to have been mailed to you. If not, you will get it. It is a report by an independent agency which looked at the success story of the first Half-Back program.

**Mr. Grande:** It was a failure story.

**Hon. Mr. Baetz:** It was a failure story? Then you see things through one light and I see them through another. I guess we just don't speak the same language.

**Mr. Grande:** We most certainly don't. Have you read an evaluation of that program? Are you aware of it?

**Hon. Mr. Baetz:** I certainly have. I wouldn't be sitting here if I hadn't.

**Mr. Grande:** Can you say more other than what you have said?

**Mr. Vice-Chairman:** These are rather informal proceedings. You have made your comments, Mr. Grande, and the minister has; and he listened carefully to yours. When we get into vote-by-vote discussion. I am sure you can pursue this in the most minute detail.

**Mr. Grande:** You are quite right.

**Mr. McClellan:** Surely the minister intends to respond to the concerns that were raised with respect to Wintario grants?

**Hon. Mr. Baetz:** Yes, indeed I do. I will give you a detailed response.

**Mr. McClellan:** You have to have someone write that for you, do you?

**Hon. Mr. Baetz:** No, I do not have to have somebody write it for me. I want to get the exact statistics.

**Ms. Gigantes:** Statistics?

**Hon. Mr. Baetz:** I am aware of what happened there. We have nothing to hide, I can assure you.

**Mr. McClellan:** When will we have that? We can bring it to public accounts if we can't have it dealt with here.

**Hon. Mr. Baetz:** We can have it later this afternoon.

That concludes my truncated and informal remarks.

On vote 3002, heritage conservation program; item 2, heritage administration:

**Mr. Vice-Chairman:** Thank you very much. We will proceed with vote 3002, item 2. We have with us today representatives from the Royal Ontario Museum, the first order under that vote. Do you have the representatives for examination?

**Hon. Mr. Baetz:** Yes. We had the chairman of the Royal Ontario Museum as well as the executive director here. I see the chairman

has left, but Dr. Cruise, the executive director of the Royal Ontario Museum, is here.

**Mr. Vice-Chairman:** Dr. Cruise, do you have any short statement you would like to make or are you just going to respond to questions from the committee?

**Dr. Cruise:** The only short statement I would make is that Mr. Hermant, the chairman of our board of trustees, and I had arranged a week ago to meet with our staff of 350 people at the museum at 3:30 this afternoon. This concerns our budgeting process, about which some of you have read in the newspapers today. We felt that one of us simply had to go and so I am apologizing for our chairman's absence at this time.

**Mr. Eakins:** I just want to make one quick observation about your program. Recently I had the opportunity to meet with—I forget the gentleman's name, a doctor who is a specialist in fish sanctuary.

[3:15]

**Dr. Cruise:** Probably Dr. Crossman.

**Mr. Eakins:** Dr. Ed Crossman, that's right. I was quite impressed with his work. Could you bring me up to date on the amount of funding his work receives? I was interested to note that the great bulk of the financial contribution to his work comes from the sportsmen's show. Is that correct?

**Dr. Cruise:** Yes, and from other ministries. A very small proportion of the budget of the Royal Ontario Museum, the provincial grant operating budget, actually goes to support research, even though the Royal Ontario Museum has 20 curatorial departments and 75 curators, one of whose prime responsibilities is research on the collections which we hold.

**Dr. Crossman,** like many of our curators, through cross-appointments to Ontario universities which give them access to federal funding bodies such as the National Research Council and the Humanities Research Council, garners in the majority of the support for research work from these external sources.

**Dr. Crossman** has very good working relationships with the Canadian National Sportsmen's Show and with the Ministry of Natural Resources. Actually there are about six Ontario ministries with whom we actively co-operate and from whom we receive some funding for research projects.

**Mr. Eakins:** In other words, you make a contribution to his research. Is he supported in his research through the Ministry of Natural Resources or through other ministries, other than the sportsmen's show?



**Dr. Cruise:** Through the Ministry of Natural Resources and through the sportsmen's show, definitely, in Dr. Crossman's case.

**Mr. Eakins:** I think he's one of the unsung heroes in the work he is doing. I feel, from my observation, that he's very much underfunded in the work he's doing. I'm not sure where the responsibility lies to increase the research funding to support him; whether it should be through Natural Resources, Mr. Minister, or through your ministry to the Royal Ontario Museum.

I wanted to make the point that I think the work he is doing is just tremendous and I strongly support that the funding should be increased. I know the minister made some remark previously to the effect that perhaps we should be looking in other directions for funding. This is one particular area in which Dr. Crossman's work is strongly supported from the success of the sportsmen's show. Are you aware of this, Mr. Minister?

**Hon. Mr. Baetz:** Yes, I am.

**Mr. McClellan:** Dr. Cruise, I wanted to ask you what's happening at the museum. I didn't see today's newspaper until about 10 minutes before coming into the meeting here this afternoon. I've had a chance to read it, although only quickly. The article in today's Star—I don't know whether the minister has had an opportunity to see it himself—

**Hon. Mr. Baetz:** I skim read it.

**Mr. McClellan:** —by Hanoch Bordan makes very unhappy reading. The opening paragraph states: "There's a crisis brewing at the Royal Ontario Museum—perhaps the worst in its 65-year-old history—with its senior scholars close to open revolt against its director, James Cruise."

The body of the article talks about the enormous unhappiness within the curatorial staff as a result of reallocations of resources within the museum away from the curatorial departments and into other areas of the museum's operations; concern is expressed about the management. To sum up, a little sentence in the body of the article: "An indescribable state of unhappiness." That's a quote from somebody who works there. What's happening there?

**Dr. Cruise:** Mr. Chairman, may I speak in general terms about the Royal Ontario Museum? First of all, the board of trustees of the Royal Ontario Museum, 17 of whom are appointees of the Premier—excuse me, 16 out of 21 board members are government appointees—in 1974, initiated a very tough study of the Royal Ontario Museum

as an institution. They tried to enunciate long-term goals for the institution and, of course, to get on with organizational and physical planning in order that the museum might have physical housing that would be adequate for the 21st century.

It didn't take the board of trustees very long to realize that as a public institution it was essential that some basic changes be initiated and instituted at the Royal Ontario Museum. Seventy-five curators, many of them world-renowned scholars and scientists, were working away in some instances in ivory towers, not very much interested in public service, perhaps well known to professional colleagues around the world but not well known at all to the people of Ontario.

Our board of trustees knew that we must return to public gallery use the large amounts of public gallery space which had been encroached upon since 1934 to accommodate a growing staff and tremendously growing collections.

Among the many decisions in 1975 was that it was time for a change in my position. They invited me to go to the Royal Ontario Museum, not as a person with museum experience, but as a person with academic administrative experience who, it was hoped, would know and understand the academic way of life—academic tenures, sabbatical leaves and all kinds of special situations that obtain to academic people.

I went to the Royal Ontario Museum as a clearly identified change agent. The staff were nervous about change. I was nervous about the job, because it is a multi-faceted one, especially now when we are raising funds and engaged in the planning of a major physical expansion and renovation while at the same time we have less than adequate operating funds.

The particular article in today's Toronto Star is, as you might imagine, filled with inaccuracies and misquotations and all. Ever since I went to the museum, I have been told almost weekly that the morale of the staff now is at an all-time low. Morale there ebbs and flows as in other institutions. But I had a meeting this morning of all members of all the curatorial departments; they were all invited, and about 150 people turned out, including Dr. Peterson, who is responsible for this article. I explained the fiscal situation of the museum and solicited their advice. Some of them had already seen the article; I didn't know of its existence yet at that time.

In any case, there have been no major changes in priorities amongst the streams.

In case this expression "the streams" confuses any of you, we have organized 23 curatorial departments; we have education and communication departments; and then we have administration and facilities.

Education and communication is tremendously important, because I see the Royal Ontario Museum as a public institution, publicly founded, and with a responsibility and a commitment to communicate through formal classes, regular galleries, changing special exhibitions and television, radio and other media.

We are actually doing a very spectacular job. Forgive my immodesty, but we average 1,000 students a day; we had more than 200,000 students use the facilities of the Royal Ontario Museum last year. We have an attendance ranging between 1,000,000 and 1,300,000 visitors annually. I am sure that we are one of the major tourist attractions of southern Ontario.

The basic research to which reference has already been made covers 20 different curatorial departments.

We have the only department of Egyptology in Canada. With the King Tut exhibition coming to the Art Gallery of Ontario, our Egyptologists are extremely busy, our volunteer members' committee is planning special fund-raising tours of our Egyptian galleries, et cetera.

I think what is going on right now between the museum and the AGO is an outstanding example of inter-institutional co-operation. The King Tut exhibition might have been at the ROM except that we had torn down our special exhibition hall, and our new special exhibition hall won't be ready until 1982, provided the cash flows make it possible for us to complete the renovation of the existing museum building by 1982. We are living with 45-year-old electrical wiring, and what plumbing and heating there is is antiquated and unsafe. We hope to get on with that work.

If Mr. Hermant, the chairman of our board, were here, he would explain that the kinds of tensions that are referred to in this article actually are more or less creative ones. Those of you who have been watching the history of the Royal Ontario Museum for the past 25 years know that the curatorial staff has been in a more or less constant state of uproar. I would challenge any of you to become the chief executive officer at the ROM and survive more than three years. I'm not exactly offering my position, but maybe come tomorrow I will.

Excuse me, Mr. Chairman, for the levity.

**Mr. McClellan:** I think that was a helpful overview. I want to pick up on what I had interpreted as the nuts and bolts of the current brouhaha; that is, the tension between the scholarly function and what you have characterized as the public gallery use function.

I'm a Toronto member, but all of us, especially those of us who have the luxury of living in Toronto and having access to the museum, cherish it for both functions, for the public education function and for the scholarly and research function. We would be very saddened if we had this kind of impossible choice between providing adequate gallery space for the exhibits you have on the one hand, and chopping the scholarly function on the other.

The question is, are your budgetary problems sufficiently severe that you are faced with that kind of draconian choice?

**Dr. Cruise:** Mr. Chairman, may I answer the honourable member? Our budgetary problems are so severe that, first of all, the chairman of our board and I have an appointment with the minister for next Tuesday afternoon at 5 o'clock. We're going to make a very poignant appeal to him and perhaps even, through him and with his blessing, to Management Board.

Because of the renovations of the Royal Ontario Museum, we're going to have to close parts of the public galleries to the public. It's impossible to do the renovations otherwise. This cuts into our ability to generate revenue.

For the next fiscal year, two thirds of the museum's public galleries will be closed for seven twelfths of the fiscal year. For the following year, 100 per cent of the public galleries in our main building will be closed for the entire fiscal year. In 1981-82, the third fiscal year, the museum will be totally closed for nine twelfths of the fiscal year.

We will be losing \$500,000 in gate receipt revenue this coming year and \$1,000,000 over each of the next two years. We are currently generating about \$1,000,000 a year from gate receipts.

Our situation is such that, if we give a four per cent increase in the salary-plus-benefits package to our staff, then we have to find \$604,000 through cutbacks in programs and possible layoffs of staff. The board would like a budget tabled with it by Wednesday of next week; so we are under considerable pressure.

The stream allocations have been completed and, regardless of what it says in the article, let me tell you that 61.5 per cent of our operating grant is in the cura-



torial stream, 31.5 per cent is in the education and communications stream, and the residue is in administration and facilities. This includes heat and light and all sorts of fixed costs; including rent, because the museum operates from seven rented off-site locations. I mention this only as an indication of our need for the expansion and renovation program.

[3:30]

**Mr. McClellan:** Thank you. Perhaps you could summarize your financial position for me in light of your initial opening statement that you had less than adequate operating funds. I take it from what you've just said that has led to the current state of unhappiness. What is an adequate operating budget for the Royal Ontario Museum? By that I mean a budget that would preserve the very excellent scholarly stream that has been built up over the last 30 or 40 years—

**Dr. Cruise:** Sixty-five.

**Mr. McClellan:** —65 years; and secondly, would permit you to provide sufficient public gallery space for the collections the museum has and is forced to warehouse because of an inadequate display space?

**Dr. Cruise:** I think this question combines perhaps our capital project with our operating budget situation. But with regard to the operating budget, we are of course a very labour-intensive operation. Eighty per cent of our provincial grant is required for staff needs. Our provincial grant was allocated to us with a four per cent increase on the salary component of our total and with the other components straight-lined. This works out as a 3.38 per cent increase.

Many of our fixed costs are increasing in the range of 18 to 20 per cent per year. We are billed by the University of Toronto for our heat and electricity and telephone service. We have no control over the escalations there. This is why, to give a four per cent salary plus benefit increase to our staff, and to hang onto the staff we've got, we've got to find \$604,000 somewhere. We don't have that much money in goods and services, even if we eliminated completely paper and typewriter ribbons and that sort of thing.

So we are in a very serious situation. We will either have to lay off between 15 and 25 staff members and also cut back \$200,000 on programs, or because of the short-term emergency nature of our situation it may be possible to obtain even some special lottery assistance or something. We're going to appeal to the minister for whatever help he can provide for us.

Perhaps it's unfair to be speaking this way because the minister hasn't had a chance to hear us out.

**Mr. McClellan:** We can follow that up in a minute, but what are your capital needs?

**Dr. Cruise:** The province has been very generous regarding our capital. The province has given \$12,750,000 and the province has sequestered \$10,400,000 of Winario money. We haven't asked for more from the province. Our chief problem with regard to our capital project is the lack of a federal commitment. We appealed five years ago for a federal grant of \$15,000,000 because the Royal Ontario Museum is the largest and most important museum in Canada. We're also an associate museum of the National Museums Corporation and it's only fair and reasonable that the federal government would make a very substantial commitment to our capital project.

The honourable Mr. Baetz has been extremely supportive of our appeal. He has gone with the representatives of the museum to the Prime Minister's office. He has cabled and telegraphed the Secretary of State with regard to Loto Canada moneys and that sort of thing. He's really very strong in support of our need for federal capital support.

**Mr. McClellan:** I just wanted to ask a final question and that is of the minister. What action do you intend to take?

**Hon. Mr. Baetz:** Action in respect to what? The problem that has just been pointed out by Dr. Cruise? As I think he mentioned, I have not had a chance to look at the details at all.

**Mr. McClellan:** This is all news to you?

**Hon. Mr. Baetz:** This emergency thing is new to me.

**Mr. McClellan:** Surely you must have been aware of the financial constraints the museum has been operating under; or do the 19 provincial appointees not keep you informed of developments at the museum?

**Hon. Mr. Baetz:** Oh, of course they do.

The province has increased its operating grants over the last three years by an average of about 7.1 per cent a year. While it's certainly not going to result in ROM living in the lap of luxury, it's about consistent with increases to other sectors of government spending. Also, as Dr. Cruise has mentioned, we are deeply involved in the capital expansion program, to the tune of over \$22,000,000.

I think he has touched on something here that goes back to the broader question of



some arrangement between the federal and provincial governments in determining, in a more comprehensive manner, what are our respective responsibilities to some of what I would call our flagship cultural institutions in this country. As Dr. Cruise has mentioned, ROM is an associate of the National Museums Corporation. One could assume, surely, that with that kind of a close association the federal government would undertake a very considerable responsibility for providing some ongoing money for the institution, that the federal government at any time will say—

**Mr. McClellan:** I didn't ask you for an attack on the federal government. I'm quite capable of making that myself.

**Hon. Mr. Baetz:** No, it's not an attack on the federal government at all.

**Mr. McClellan:** I want to know what action you intend to take with respect to the less-than-adequate operating funds; the point the director has brought before this committee today.

**Hon. Mr. Baetz:** We can go back at it again and see just what can be done, but it's a difficult thing. This is not an attack on the federal government, but I think the basic question has to be answered: what is the respective responsibility of the federal and provincial governments for financing some of our nationally- and internationally-renowned—

**Mr. McClellan:** You respond to all questions with that excuse. You respond to issues with respect to native people; you respond to questions with respect to immigrants; you respond to problems with respect to our cultural institutions with this shell-and-pea game.

**Hon. Mr. Baetz:** Yes, and with great legitimacy because there are dual responsibilities.

**Mr. McClellan:** In the meantime, problems fester until they boil over and treasured institutions become at risk; it's intolerable.

**Hon. Mr. Baetz:** I don't think we have ignored the Royal Ontario Museum; I don't think the level of support for operating would suggest that. I don't think you can say that with regard to the more than \$22,000,000 in capital assistance. I don't think the efforts we have made to try to get the federal government, which claims some of the responsibility for ROM but hasn't given a dime up to now for their capital program—

**Mr. McClellan:** The museum's space problems are historic. They have had an

unparalleled collection that rivals any museum in the world which they have been unable to display for decades. It isn't something new just because you finally got around to doing what should have been done many years ago. Don't expect us to pat you on the head. I'm not even addressing that. I'm addressing the serious crisis with respect to their operating budget. You keep wandering in the direction of Ottawa. The direction is right here at this table, in your chair.

**Hon. Mr. Baetz:** I take responsibility for that, yes. I don't duck it but I do not accept your point of view that Ottawa has no responsibility at all.

**Mr. McClellan:** I didn't say that at all. I said I was quite capable of attacking Ottawa on my own initiative.

**Hon. Mr. Baetz:** All right, but would you not then agree that perhaps—

**Mr. McClellan:** I want to know what you're doing.

**Hon. Mr. Baetz:** —as between the federal and provincial government in this instance the government that ought to be attacked more is the federal government which has given nothing?

**Ms. Gigantes:** Are you looking to the federal government for operating funds?

**Hon. Mr. Baetz:** I don't think it would be inappropriate at all.

**Ms. Gigantes:** It may not be inappropriate but it is too late.

**Hon. Mr. Baetz:** The federal government gives grants to the National Ballet, to the Canadian Opera Company and to all kinds of institutions. Why not to one of the world's greatest museums?

**Ms. Gigantes:** It is the Royal Ontario Museum.

**Mr. McClellan:** It is a very depressing situation.

**Mr. Grande:** Dr. Cruise, I just have one question. I just don't understand what you were saying, about the ministry having sequestered \$10,000,000 from Wintario. Could you expand on that?

**Dr. Cruise:** Perhaps I used the wrong verb. We have been assured by the Wintario Corporation that \$10,300,000 has been set aside and will be available on a matching basis to match the moneys that are being currently raised through our private sector fund-raising campaign, which has now reached the \$6,700,000 mark. We have a \$10,000,000 goal which we will reach. The additional \$400,000 was in connection with

special facilities for the handicapped over and above those required by the building codes. I believe those will be financed 100 per cent by Wintario. I think that is the reason for the extra \$400,000 that I mentioned in connection with the \$10,400,000.

I think sequestered just means that they are holding it. They have made a commitment to provide that money as we are prepared to spend the portions of the money we have raised. As we spend it, it is my understanding that they will then match it. So that our \$10,000,000 from our campaign, when successfully completed, will mean \$20,000,000 towards the project.

**Mr. Grande:** The point I would like to make clear is whether you, as the minister, are counting on that \$10,000,000 that comes from Wintario to help the Royal Ontario Museum with its operating expenses.

**Hon. Mr. Baetz:** No, this is just capital.

**Mr. Grande:** Obviously, you are having trouble raising the \$10,000,000. Is the private sector not coming through?

**Dr. Cruise:** We are not really having trouble. Naturally, the first \$5,000,000 is easier to raise than the last \$5,000,000. I had no experience in professional fund-raising until I went to the Royal Ontario Museum. We began a two-year campaign on May 9, 1978. In less than one year we have reached \$6,600,000 towards our goal of \$10,000,000. We are just at the stage now of working with special individual friends of the museum, and there are still some major foundations that are in the process of making their commitments. We have every confidence that we will reach our goal.

We are in obvious open competition with Massey Hall, with Queen's University, with the ballet and many other worthy institutions. We wish them all success. We knew when we launched our campaign that there was no ideal time. One could never wait until no other agency was in the field. We knew there would be money enough for everybody, but it would take longer for each of us to raise it. I think that is indeed going to be the case, but I think that within our two-year limit we will reach our goal.

**Mr. Grande:** Thank you, Dr. Cruise. I have no more questions.

**Mr. Vice-Chairman:** Dr. Cruise, I wonder if I might pose a question to you. On the completion of your capital investment, do you see a substantial increase in revenue generated at the museum? Is it projected?

**Dr. Cruise:** Definitely, in several ways. The 1,000 school students per day are all pre-

booked. We could have 2,000 students per day now if we had the gallery space for the classes. So we will book right to the maximum level; and the same with our planetarium theatre of the stars.

[3:45]

We are gearing up very successfully, regardless of what you might hear through the media, in many aspects of our educational program. We are making print, film and tape materials available to classrooms throughout Ontario. We have volunteers, very well-informed volunteer docents who will go to classrooms and prepare an individual class and teacher for their Royal Ontario Museum visit. The volunteers know whether the classes want to see Egyptian galleries, Greek and Roman life, mineralogy, ichthyology and herpetology, or what have you, and prepare the classes so that the museum visit will be more significant.

We are into many areas of revenue generation. Our book and gift shop and our restaurant are going to be larger and better; they are going to be profit centres.

**Mr. Vice-Chairman:** Does anyone else have any questions of Dr. Cruise?

**Mr. McClellan:** Just a final request of the minister. I gather from Dr. Cruise that there will be a meeting on Tuesday.

**Dr. Cruise:** We have an appointment with the minister on Tuesday at five o'clock.

**Mr. McClellan:** I would like to ask the minister to report back to us on the fruits of that meeting as quickly as there are fruits; and let me tell him that we expect it to be a fruitful meeting. We will be very unhappy if our museum—and it is not just a Toronto museum; it is the facility for all the people of Ontario—is allowed to suffer, and it is clear that it is suffering now.

**Hon. Mr. Baetz:** I can assure you, Mr. Chairman and members of the committee, that I will continue to do my utmost to keep this institution, which is a Canadian institution of world renown, functioning.

**Mr. McClellan:** Universal; cosmic.

**Hon. Mr. Baetz:** To show how hope springs eternal in the human breast and how we are all optimists, with the museum being virtually closed to the public over the next two or three years, I had assumed in my own mind that operating costs would be substantially reduced because staff who are there to help the public go through would obviously not be needed for two or three years. Obviously we will have to find out all about that next Tuesday.



**Mr. McClellan:** Just so that it is clear. We do not want the scholarly function to suffer.

**Hon. Mr. Baetz:** I've got that message.

**Mr. McClellan:** And we want the public access to expand.

**Hon. Mr. Baetz:** That's after the expansion program.

**Mr. Vice-Chairman:** Thank you very much, Dr. Cruise. I am looking forward to hearing the results of the meeting that the minister has with you next week.

Now, with the indulgence of the committee—

**Ms. Gigantes:** I have one more question on this item. When was that meeting set up with Dr. Cruise?

**Hon. Mr. Baetz:** There was an appointment made—I don't know—some weeks ago.

**Dr. Cruise:** Perhaps 10 days ago, Mr. Minister; I am not sure.

**Hon. Mr. Baetz:** We're aware of the agenda. We meet frequently and—I think Dr. Cruise would support this—they are very mutually satisfying meetings we have.

**Ms. Gigantes:** I am sure you find it so.

**Dr. Cruise:** Mr. Chairman, could I respond to that?

This may seem fatuous, and perhaps it is unnecessary, but I just want to say that the relationships between the Royal Ontario Museum and the Ministry of Culture and Recreation are close and warm and effective.

We accept the fact that, at a time when hospitals and schools are being closed, it is not easy to make additional funding available to the Royal Ontario Museum. We are very prepared to consider the laying off of every single staff member who can be considered redundant in any way because of partial closing of the museum. But, as it works out, there aren't very many people who are not needed. You can understand that security guards are perhaps more important while we have dozens of workmen, maybe 100 workmen, in the museum carrying out renovations. It just isn't easy for us to substantially reduce our complement, in spite of the fact that our public service will be reduced for this period of time.

**Mr. Vice-Chairman:** Thank you again, Dr. Cruise.

**Mr. Grande:** Did he have to say that when he's coming before you on Tuesday to ask for more money? I don't understand that.

**Mr. Vice-Chairman:** You asked for it. I would like to share this particular thought with the committee. We have digressed somewhat from going in order through the

votes to enable us to hear those people who may find it difficult to get back. With your permission, we are going to go to another item in the vote to accommodate someone we have with us. Is that right?

**Hon. Mr. Baetz:** Yes. It is the chairman of the board of OECA—TV Ontario.

**Mr. McClellan:** Because of the time shortages, I personally don't have any questions of the other institutions. Other members may.

**Mr. Grande:** I have no questions under vote 3002-2.

Items 1 and 2 agreed to.

**Mr. Vice-Chairman:** The minister has a request that we have someone with us who would like to be heard?

**Hon. Mr. Baetz:** I am simply saying they are here, if you wish to raise some questions to them under vote 3003-1. Under that, we have present the chairmen of the boards of the Ontario Educational Communications Authority, the Art Gallery of Ontario, the McMichael Canadian Collection, Royal Botanical Gardens, CJRT-FM, Ontario Arts Council and the Ontario Science Centre, which is under a different vote.

**Mr. Grande:** Going by this sheet that was prepared, under vote 3002-2, which goes as far as the Ontario Arts Council—

**Hon. Mr. Baetz:** No.

**Mr. Grande:** Sure it does.

**Mr. Vice-Chairman:** It's under 3003. There's another vote in there, Mr. Grande. Vote 3003-1.

**Mr. Grande:** I'm sorry.

**Mr. Vice-Chairman:** The only problem we have when we digress from the estimates as they are written is that someone may not be prepared or ready to examine some of the people we have before us. It is only with your permission that we would carry on.

On vote 3003, arts support program; item 1, cultural development and institutions:

**Hon. Mr. Baetz:** To help the committee and you, sir, under vote 3003-1, the following agencies, as far as I can determine, are included: the Art Gallery of Ontario, the McMichael Canadian Collection, the Royal Botanical Gardens, CJRT-FM and the Ontario Arts Council. The others come under different votes.

**Mr. Grande:** Under the Ontario Arts Council, I have something for the minister, but not necessarily for the Arts Council. It is a policy matter.

**Mr. Vice-Chairman:** Are there any others on this list you would like to question? You



will deal with the votes then with the minister and not with anyone else who might be here. Is there anyone else on the committee who would like to speak?

Under vote 3003-1—and I just ask the question again to be certain that we have the same understanding—there is no one on that list you would care to question, other than the minister?

**Mr. Grande:** I want to question the minister regarding the Ontario Arts Council.

**Mr. Vice-Chairman:** You just want to address the minister on that, then. If that is the case, I guess we can dispense with those people.

**Hon. Mr. Baetz:** Under vote 3003-2, which is a different vote, we have the Ontario Science Centre. Under 3005-2, we have OECA, if you want to deal with those.

**Mr. Vice-Chairman:** Do you have any questions of the staffs of those organizations? You will direct all your questions to the minister?

**Mr. Grande:** Either the minister is thoroughly confused or I am.

**Hon. Mr. Baetz:** I am not confused.

**Mr. Vice-Chairman:** I don't think Mr. Grande has this one on his list.

**Mr. Grande:** That's correct, I don't. This is the list for today. That's what I'm referring to and we're talking about vote 3003-1 after vote 3002-2. Are we going to that? All I am saying is that, under the Ontario Arts Council, I have a policy matter to raise with the minister. I have no questions about any other institutions that come under that particular vote on this sheet.

**Mr. Vice-Chairman:** Now, the only obstacle is that the minister himself may like to have some of these people here react to the questions. That's entirely up to you.

**Hon. Mr. Baetz:** I think they could be excused. I know they're busy.

Mr. Chairman, there are only five agencies under vote 3003-1. The Ontario Educational Communications Authority is under vote 3005-2.

**Mr. Grande:** We're not dealing with that right now.

**Hon. Mr. Baetz:** You want the chairman then to stay with that; to stay here until we get to that?

**Mr. Grande:** Yes.

**Hon. Mr. Baetz:** We're getting a little too far ahead.

**Mr. Grande:** We're talking about the Art Gallery of Ontario, the McMichael Canadian Collection, the Royal Botanical Gardens, the

CJRT-FM Corporation and the Ontario Arts Council under that particular vote. As far as I am concerned, I have no questions for them—only one policy question for you regarding the Ontario Arts Council. So these people, as far as I'm concerned—

**Hon. Mr. Baetz:** The Ontario Art Gallery can go; McMichael can go; Royal Botanical; CJRT-FM.

**Mr. Vice-Chairman:** Mr. Grande: if you would like to direct your question to the minister.

**Mr. Grande:** Mr. Chairman, to be fair to those people who have been waiting here, I did state the other day that I did not have questions for them. The Liberal member who is not here said he would like those agencies before us. I said I had no questions for those particular agencies. So, let's make that point clear.

**Mr. Vice-Chairman:** Right. Then you can carry on under vote 3003-1 with your questions to the minister relating to the Ontario Arts Council.

**Mr. Grande:** Mr. Minister, it's more a question relating to policies and one that I raised last year. I just want your thoughts on the matter. As far as I am concerned it is regarding the establishment of the Ontario Arts Council which operates at arm's length from the ministry. Its main function is to encourage different forms of artistic expression in this province.

My point is: Particular groups or organizations get money from the Ontario Arts Council, and some, especially, receive hefty sums of more than \$100,000—and, as far as I'm concerned, those particular groups and organizations have a tremendous expertise within their own four walls. Would you accept a policy direction, in terms of getting those particular organizations to deal directly with you as does the McMichael Collection, as does the museum, and the other 13 or 14 cultural institutions? That's the policy direction I'm looking for. So then you would allow the Ontario Arts Council to deal with individual people and with small groups, to encourage them to create their art or do whatever they would like to do.

**Hon. Mr. Baetz:** That proposal has been made from time to time by a variety of people and agencies. It is something on which I personally have an open mind. I think an argument could be made for a more direct granting to some of the larger agencies that are established, about which nobody is really concerned any more whether

they have a high artistic quality. For example, the National Ballet.

[4:00]

**Mr. Grande:** The Stratford Festival, the Shaw Festival.

**Hon. Mr. Baetz:** There are others, yes. I would only like to say at this time that it is a matter that has been proposed. It is something that is under consideration. It is certainly not something against which I have deep-rooted feelings. I think in the course of this year I could make a commitment to you and the committee that we would take a somewhat more systematic look at this as a proposal.

We may come forward next year and actually suggest some of the agencies should be placed in a somewhat different status with the ministry. I think as we look at this I would hope to hear some rather compelling arguments to change it. You have suggested one. I would hope we could look at the whole range of pros and cons, and I think there are some.

As I say, during my stay in the ministry we have not looked at this in a systematic way. We have considered it from time to time in a variety of settings. In the course of this year we would be ready to take a systematic look at this, discuss it with the Ontario Arts Council, discuss it with some of the larger agencies, and come forward with a proposal to this committee—I guess this would be the committee—to direct us in our new approach.

**Mr. Grande:** It's heartening to hear that. I don't want to repeat it. I really strongly feel that the Ontario Arts Council should be dealing with the smaller groups and should be dealing with individual artists and writers in this province, and should encourage and support those particular groups or individuals I mentioned.

**Hon. Mr. Baetz:** Say we turn over to the arts council the responsibility in a real sense for setting priorities—that's what they're really doing—as to how much money goes to the individual, to the budding artist, to the newcomer, how much goes to the smaller agencies as compared to how much do the bigger agencies get—it's that whole range of priorities—if that is the responsibility of the arts council, I have heard it argued that in fact the trend should be in the opposite direction. In fact, all the agencies in the cultural field should be reviewed and receive their grants through the arts council. I'm simply saying that is another argument that one hears.

**Mr. Grande:** You might hear that argument, although I've rarely heard that argument, but certainly I've heard many times the argument I'm putting before you today. I don't know what the Ontario Arts Council is going to say to the Royal Ontario Museum about what they should be running and about the artistic quality of the work they're doing, or the educational work they're doing.

**Hon. Mr. Baetz:** ROM is not in it.

**Mr. Grande:** I realize that, but you were making the argument that they should all be included. That's what I'm saying to you.

**Hon. Mr. Baetz:** I wasn't making it. I was saying some people have made the argument. I suppose there's always the hope among some of the larger agencies that if they got their grants directly from the ministry they would get more than they're getting through the arts council. That doesn't necessarily follow, if the well is low in water to begin with.

**Mr. Grande:** I think it's up to you, obviously, how you deal with those agencies, as it's up to you how you deal with the McMichael Canadian Collection. All I can do is come to you and say the way you're dealing with it is not proper, is not right.

**Hon. Mr. Baetz:** There is, admittedly, a certain inconsistency in it, yes.

**Mr. Grande:** I have no further questions of the minister under that vote.

Item 1 agreed to.

On item 2, Ontario Science Centre:

**Mr. Vice-Chairman:** If there are no other questions in those particular areas, there is one more item under vote 3003-2. I don't know if it is on your list but if we deal with it, we can get that vote done. It is the Ontario Science Centre.

**Hon. Mr. Baetz:** Tuzo Wilson is here, I understand.

**Mr. Vice-Chairman:** The director general is here with us. Could we deal with the second part of that vote? Are there any questions? No questions of the vote?

Item 2 agreed to.

Vote 3003 agreed to.

On vote 3002, heritage conservation program; items 3 and 4, Huronia historical site and Old Fort William.

**Mr. Vice-Chairman:** If we deal with those two, we will have those two votes done. Do you have any questions there, Mr. Grande?

**Mr. Grande:** I have no questions, Mr. Chairman.



Items 2 and 3 agreed to.

Vote 3002 agreed to.

**Mr. Grande:** If the minister is prepared to respond to the part of my leadoff to which he did not respond, this would be a good time for him to interject.

**Mr. McClellan:** Let's go back to the first vote, which is ministry administration, which is an appropriate place to pursue some of the things that came out of the three lead-offs in the response.

**Mr. Vice-Chairman:** You could ask the question at the same time, which might be helpful to the minister, if you want to talk to these people in this vote.

On vote 3005, libraries and community information program; item 2, community information:

**Hon. Mr. Baetz:** Could I just make one more plea to the committee, that you deal with vote 3005-2, which is the Ontario Educational Communications Authority. They are here and I know they are anxious to get going.

**Mr. Grande:** I actually think we dealt with it.

**Mr. McClellan:** I think they can be dismissed, but I don't want to pass the vote because we have some comments on the vote.

**Mr. Vice-Chairman:** No, that is all right. I don't want to pass the vote. I want to be certain we understand they are here and available. Are there any other questions of that group?

**Hon. Mr. Baetz:** There weren't up until now.

**Mr. Grande:** As far as I am concerned, we had very satisfactory answers in the last estimates and I have no need to pursue it.

Vote 3005, item 2, agreed to.

On vote 3001, ministry administration program; item 1, main office:

**Mr. McClellan:** I have a couple of questions to pursue out of the minister's lead-off, if you will just bear with me for a second.

I have been reminded, and the appropriate place to do it is under the first item of the first vote, that the minister hasn't completed his responses to the leadoff.

**Hon. Mr. Baetz:** I realize, Mr. Chairman, I must reply to Mr. Grande's reference to the Ashbridge's grant. There is a possibility to do that under the last item under Wintario capital support and I am ready to deal with it.

**Mr. McClellan:** Let's do it now. We have a time problem. I don't know where we're going to get to during the course of these estimates.

**Hon. Mr. Baetz:** We can do it now, I suppose.

**Mr. McClellan:** I assume the minister will want to take the opportunity now to respond to the Ashbridge's grant. We are having trouble today, aren't we?

**Hon. Mr. Baetz:** The final payment of the Wintario grant, as I believe Mr. Grande has pointed out, was made in the amount of \$55,130.55; it was made in February. That was preceded by a letter from the deputy, as you indicated, which stressed the ministry's position with regard to the compliance by the club with the requirements and conditions of Wintario participation in the project, reaffirming that should the club, within 10 years of receiving Wintario funds, not comply with any of the conditions of the agreement, "the ministry shall be entitled to request repayment of the whole or any part of the Wintario funds."

That is the clause that is in every agreement with a private club, as Mr. Noon can confirm.

The club confirmed in writing in March—and if we have time, we may have the letter; I don't know—that a set of guidelines had been formulated by the club's Wintario committee which outlines its official attitudes and relationships to the public. The ministry's field representative, Mr. Sehmrau, is part of the committee in order to maintain this continuing monitoring of the terms of public accessibility. The ministry's field representative has stated that these guidelines are presented to promote the atmosphere of a facility which in fact invites community use. His role on the committee is as an organizational developer. In other words, he will encourage public use.

Our representative states that there is all kinds of evidence that the nucleus of the club and the majority of its members have an unselfish attitude as far as having the general public participate is concerned. He has also stated that because the facility is not altogether completed this has hampered the ability of the club to properly develop these public programs.

**Mr. McClellan:** What does "participate" mean?

**Hon. Mr. Baetz:** Well, to participate in the activities of the club.

**Mr. McClellan:** Obviously. But can you be more specific? What kinds of activities?



**Mr. Wright:** Mr. Chairman, I could provide some further detail. I myself am not entirely familiar with it, but I have a file of correspondence. I believe the ministry field representative who has been dealing with this is here and might even be able to answer further questions.

We have here a copy of a letter addressed to the ministry from the commodore of the club, indicating that they have formulated a set of guidelines. We have copies of the guidelines, and we would be very pleased to make them available to you. They provide in two pages a very complete listing of the sorts of things they have established. I'd be pleased to read these, if you'd like, or simply to provide you with copies of them.

**Mr. Grande:** I just want to know the date of that letter.

**Hon. Mr. Baetz:** March 10, 1979.

**Mr. Grande:** In other words, what you are saying is that, after the then deputy minister had told the club it would have to make sure that there was accessibility to the public, the club did not give you any information or send you any letter or any kind of memorandum that said that within the two weeks it was able to fulfil the ministry's conditions.

**Dr. Wright:** The notes from the meeting of the club members that dealt with all of this are dated January 27, 1979; so I presume there must have been some process within the club in which these were formulated and then had to be ratified.

[4:15]

**Mr. Grande:** No, it has nothing to do with the 10 years. The 10 years is in the standard application and the standard letter of agreement signed between the ministry and the club. However, that is so the club may get one cent, not for the club to get the last instalment of that grant. We're talking about the last instalment of the grant. You'd already given two instalments of that grant to that club and the club had not fulfilled the condition which they said they would. And you've given money to that club without being assured that the condition for public accessibility had been fulfilled. That's what this letter states.

**Dr. Wright:** Mr. Chairman, I think that the conditions could not be fulfilled until the facilities had been established. Part of it had to do with the community use of the new facilities so it was a matter of working through the implications of that original agreement, as I understand it. Mr. Seh-

rau, I believe, is here and might be much more able to answer these detailed questions.

**Mr. McClellan:** The concern is that it sounds like an afterthought.

**Hon. Mr. Baetz:** No, it's not.

**Mr. Grande:** Frankly, the concern is that this kind of thing is going on in many more private clubs than just the Ashbridge's club.

**Hon. Mr. Baetz:** I think, Mr. Chairman, that I could make this general statement about Wintario and all private clubs. There is no fooling around with them in terms of closing our eyes to their not meeting the conditions, the big condition being that of public accessibility.

I have reviewed the grants to the private clubs and I must say that in every instance I've been satisfied that the conditions of the Wintario grants were fulfilled. If they were not, we would withdraw our funding. We have taken any number of steps to make sure that these private clubs are accessible to the public and one of our best ways of assuring that is to make it known to the people living in the community, who were not originally members of the club, that the Wintario money went in there and, because of that, they have accessibility to the facilities of the club.

**Mr. Grande:** You're going back to the 1970 memo. That's fine. I'm aware of all that. This is clearly something very new that is happening, because as far as I understand it, and I'll repeat it again, the memorandum of agreement between the private club and the ministry takes place prior to the club receiving one cent. If the club is not willing to meet those conditions then the club will not get any money. What I'm saying to you is that this club has not met the conditions and you have given that club two instalments of that grant.

**Hon. Mr. Baetz:** I wonder, Mr. Chairman, if, with your permission, we could have the field representative who has been working with this particular project and who knows the thing far more intimately, appear here. Obviously, we feel that in a general way the conditions and the principle have been met or the final grant would not have been made but, perhaps with the testimony of our field representative we can get the thing more precisely into focus.

**Mr. Grande:** Mr. Chairman, with respect, I'm not concerned about the details of the grant. I'm concerned about the overall principles of Wintario and, in this particular case, those principles have been met. That

is what I am suggesting to you. It's not this particular application that I'm concerned about and in finding out the details of the application and what went on. I'm talking about the six Wintario principles and one of those Wintario principles is public accessibility. This club clearly has not provided, has not given you to your satisfaction or convinced you to your satisfaction, that public accessibility was going to be assured. You went on, still, to give them the money without the knowledge. That is what I am talking about.

**Hon. Mr. Baetz:** I don't think that is quite the right sequence. On January 24, 1979, our deputy minister, Mr. Johnson, did write to the chairman of the ways and means committee of the Ashbridge's Bay Yacht Club and in there he noted something which is, I think, very relevant. He says: "As you may be aware, the issue of this final payment has been delayed for the following reason."

There was a delay; we didn't simply just keep on paying until we had some assurance they were going to meet the conditions of the payment. "Since our ministry representative had expressed some concern with regard to the club's willingness and ability to provide the level of public accessibility which had been requested at the time of the original approval . . ."

Then he goes on to say: "I know that he has more recently met with members of your Wintario committee and indicated to you his concerns, suggesting that a set of guidelines for committee responsibilities and for the operating of club facilities in connection with promoting public participation for recreation use . . . I would emphasize his comments and insist that the club comply with his requirements within the next two weeks."

**Mr. Grande:** However, before you were assured the club had complied, you sent them the cheque.

**Hon. Mr. Baetz:** I wouldn't say that that was the case.

**Mr. Grande:** Read the letter.

**Hon. Mr. Baetz:** This is why I would hope to have the permission for the field representative to report, because in some of these cases it is a verbal communication on the basis of which the action is taken. He was in constant contact with this. If there had been a strong indication or a good likelihood that this club had no intention of meeting these conditions, not only would we not have made the final payments, we

would have said we are scrapping the agreement and we want our money back.

**Dr. Wright:** Mr. Chairman, could I add to that?

The detailed agreement was established at the time of the original application, I understand, and was sealed by the club, signifying their acceptance of this. What was at issue apparently some weeks ago was only the detailing of how they were going to act upon that agreement; there was no question about the agreement, nor their commitment.

**Mr. Grande:** You are talking about details; you are talking about one of the principles of Wintario, which is public accessibility; that is what you are talking about.

**Dr. Wright:** Yes.

**Mr. Grande:** And given that the club had not met that criterion initially—obviously not—

**Dr. Wright:** How could it have provided public access to what had not been built?

**Mr. Grande:** At least what they would have provided to you is to say, "Yes, we are going to allow for the public—"

**Dr. Wright:** They did, sir, the agreement executes all this. These are just simply further details.

**Mr. Grande:** Okay. You just explain to me what this letter means then, that even though the club had not met the conditions you set upon it you sent them money. You explain that away in some shape or form. I don't think you can. I really don't think you can.

**Hon. Mr. Baetz:** The agreement covered the whole transaction. If the club would not meet the conditions of the agreement, they would not only not have received the last payment, they would have lost the entire grant.

**Mr. Grande:** But that is what this letter says, that the club did not comply with the agreement.

**Hon. Mr. Baetz:** As my deputy said, how could the club comply with the agreement before the facilities were built? Certainly there were ongoing consultations between our field representative and the club. There were additional steps taken to make sure the public would have accessibility to this place. He is even a permanent member of one of the committees of the club, to make sure that would happen. And if the club violates the agreement, then we have every legal right and every intention in the world to get all our money back.

**Mr. Grande:** That's right. Then you have to go through expensive court actions, is that what you are saying?

**Hon. Mr. Baetz:** I did not say that, no. You said it.

**Mr. Grande:** No, I did not say it. It says here: "Abusers of Wintario likely to face lawsuits. Private clubs that get Wintario grants, but fail to meet the condition of public access, probably will be taken to court, according to a spokesman for the Ministry of Culture and Recreation. David Carmichael, director of the ministry's communications branch, said yesterday the Culture minister, Robert Welch, 'is quite prepared to take legal action to get the money back.'"

**Hon. Mr. Baetz:** Right, and we are.

**Mr. Grande:** Don't say that I'm saying it.

**Hon. Mr. Baetz:** It doesn't say we have to take court action.

**Mr. Grande:** All right. Give them the money and say no condition.

**Hon. Mr. Baetz:** It may well be that if we were to say, "Look, you have not fulfilled the terms of the agreement; you either maybe have changed your mind or you don't want to, for whatever reason—"

**Mr. Grande:** Please give us our money back.

**Hon. Mr. Baetz:** "—so give us our money back."

**Mr. Grande:** Yes, sure.

**Hon. Mr. Baetz:** And if they don't then we take court action.

**Mr. Grande:** Obviously that answer, Mr. Chairman, is really unsatisfactory. As I said before to the former minister, this direction they have taken in the past two and a half or two years is quite wrong as far as I'm concerned. Either those clubs will open their doors to the public or else they're not going to get any public money, and that is final. There should be no bending of any Wintario principles.

**Hon. Mr. Baetz:** Mr. Chairman, in view of the fact Mr. Grande has drawn a conclusion on the basis of this incident, I would still hope you would allow us the privilege of having our field representative, who has been very closely associated with this project, to testify.

**Mr. Grande:** Mr. Minister, it's a matter of policy; it's not a matter of a detailed grant. That's what I'm addressing. But you're at liberty to call upon anybody. That's the advantage of being in a committee.

**Mr. Vice-Chairman:** That's right. Yes, there's no limitation.

**Hon. Mr. Baetz:** Then I shall exercise that liberty right now.

**Mr. Sehmrau:** As I see it, there are really two questions. One, is there public access, and two—

**Mr. Vice-Chairman:** Excuse me, would you give us your name for the record.

**Mr. Sehmrau:** Yes, my name is Uwe Sehmrau. I'm the senior consultant for Metro East district. There are really two questions being asked. One, is there public access to the facility which is being funded through Wintario funds, and the other is, was the cheque issued before there was assurance? Let me address the first question first.

The question of public access to Ashbridge's Bay Yacht Club, from a programming point of view, is not an insistence that there be a demonstration of it immediately upon the application. From a programming point of view we have to make some kind of assurance the facility will have continued public use. For us to work with volunteer organizations and immediately to insist that once they start construction of this facility they demonstrate public use of that facility could destroy the nucleus of volunteers of that organization.

So we have to be very cautious as to how much insistence we put on the volunteers for putting on the effort in providing a recreational opportunity for the public. It is not necessarily a private activity. It's a recreational activity that is being privately organized for the public, and there's a distinct difference.

One of the insistences we wanted to see was the establishment of a committee that we could have put in, in order to provide the organizational development within the organization so that they understand their responsibilities for the public development of sailing programs.

The club has limited volunteer hours. They have in the past two years spent most of their efforts in fund-raising and in physical work to get the site ready. Once they can re-aim their efforts into the development of programs, I have every assurance that will happen. There has been a tremendous pressure on the club from the press, from all sorts of angles, to demonstrate immediate use of that facility by the public and it's been incredibly difficult for them to respond to that.

[4:30]

I am hoping that this project continues because sailing is a tremendously popular



activity that is not being provided for through any public means. In order for us to promote the activity of sailing, we have to use the avenue of privately organized agencies to provide an opportunity for the public. We can do that by being involved with these organizations and not insisting that they demonstrate this right now. We have to develop these organizations to understand that broader responsibility and we have that opportunity by being on the committee.

In terms of the cheque being issued, I recall very distinctly that the club continuously phoned me to find out whether they could have any further money and Michael Noon's insisting on meeting with me to make sure that these guidelines were prepared before the cheque was released. I don't think there was any release of money before there was assurance that we were totally satisfied from a programming point of view.

Unfortunately, there has been some dissent within the club. As a matter of fact, I asked the club to take the conditions of Wintario to a vote. There was one dissenting vote from the club to reject the conditions of Wintario. He happens to be the editor of their newsletter and wrote an article. That again put a lot of pressure on the club to demonstrate public use. That is one member out of more than 450 at this point.

I hope we can proceed with allowing the club to develop in a very responsible way to provide many public programs in sailing and other community recreational activities. I have been there many times at a number of community events since the facility has been established.

**Mr. Grande:** The facility is operating then.

**Mr. Sehmrau:** The club house is operating. A list of public events has been provided. In terms of the facilities for the sailing school and the public sailing program, there is still work being done. The efforts of the volunteers are still on fund-raising and physical development. We will work with them and turn their efforts to programming once they don't have to worry about the fund-raising and physical work anymore.

**Mr. Vice-Chairman:** Mr. Grande, do you have a question?

**Mr. Grande:** I am not quite finished, given that the minister wanted the gentleman to come up, because that raises a lot of questions. Perhaps we are not going to be able

to settle it here. Let me say to the minister that his Wintario principles are not geared to an ongoing type of programming and cajoling people to respond to the public accessibility issue. Your principles say either you provide accessibility or, in the vernacular, you ain't going to get the money. You should have had a demonstration of that even before the facility was built, as the deputy minister said. Now we find out the facility has been built. Even so, at least you would have had the details of how they were going to go about ensuring public accessibility. Obviously, according to the letter from the deputy minister, those details were not available to the ministry prior to the issuing of the last cheque. As far as I am concerned, I would go as far as to say that you shouldn't even have sent them the second cheque or the first cheque without those conditions being met.

We can go on on this, but obviously it is very clear that the Wintario principles can be bent, depending on who is doing the bending and who is pushing hard enough. I know of many Wintario applications where all they do is look at it and say, "We cannot fund this. Go back and goodbye." And people don't hear for months and months. With some we have ongoing negotiations, so to speak. That is totally unacceptable.

**Mr. Vice-Chairman:** Mr. Blundy, did you have a question of the witness?

**Mr. Blundy:** Yes, I do. I'm not all that familiar with this facility, but I would like to ask a couple of questions. I'm intrigued with the line of questioning Mr. Grande is following. Obviously he knows more about it than I do. First of all, are the facilities for which the grant was made complete? Yes or no? Have the facilities been completed?

**Mr. Sehmrau:** Most of the funds were for the clubhouse and they are now complete.

**Mr. Blundy:** They are completed? Okay. Has public access or use of the facilities ever been denied to anyone yet?

**Mr. Sehmrau:** Not that I know of.

**Mr. Blundy:** Mr. Grande seems to think there has not been the kind of assurance provided to the ministry, to Wintario, that is called for under the rules of a Wintario grant. In your opinion is that correct or is it incorrect?

**Mr. Sehmrau:** We made special terms and references for this particular application which actually went beyond the normal requirements of a Wintario application, and

all of those have been met. I know there are people outside this project who feel the terms and conditions should have been stiffer or more complex, but those were the ones we required. All the ones we insisted on—the most important being that of the establishment of the committee—have been met.

**Mr. Blundy:** That's really what I want to know. I am not in any position to argue the validity of the conditions laid down for the Wintario grant, but all the conditions that were laid down to meet the requirements of the Wintario grant have been met?

**Mr. Sehmrau:** Yes.

**Mr. Blundy:** And nobody has been refused any use of the facilities under those conditions?

**Ms. Gigantes:** As a member.

**Mr. Blundy:** Public access to the facilities has never been refused.

**Mr. Sehmrau:** No.

**Mr. McClellan:** Could I dock my yacht there?

**Mr. Sehmrau:** No. As a matter of fact, the committee has been active in developing—

**Mr. Blundy:** There seems to be some evasiveness here.

**Mr. Eakins:** Do you have to pay a membership fee to use the facilities?

**Mr. Sehmrau:** No, you can visit the club any time. The committee has developed an information booklet which provides information to anybody entering the yacht club as to how they can participate in the various programs.

They have a public sailing program whereby you can crew. You can register for a day. You can go there on a Saturday—they're always looking for crew members—and you sign up for the day. Obviously, that can't be demonstrated now because you can't go sailing now.

There will be a summer sailing school. The registration for that will be fully open, on an equal basis. I think the programs will expand once the organization has the volunteer effort to work on this.

**Hon. Mr. Baetz:** If one were really to follow to a logical conclusion this criterion that you do not get paid until you have met the conditions of the agreement—you don't get paid until you've met them—I would like to point out that this agreement runs over a period of 10 years. This would mean we'd have to wait for 10 years and then the club could say, "Now we've met

our conditions. We've had the public coming in here for all this period of time; now we are eligible for our Wintario grant."

Obviously, if you want to help a club you can't wait for 10 years to make your payment, or even your final payment. You have to go on some—

**Mr. McClellan:** There isn't a yacht club in Timmins.

**Mr. Grande:** Why are you being on the defensive?

**Hon. Mr. Baetz:** I'm only being on the defensive when I think the program is being incorrectly attacked. That's all.

**Mr. Grande:** I'm not attacking the program.

**Hon. Mr. Baetz:** You're attacking this project.

**Mr. Grande:** I'm talking to you about the principles that were established back when Wintario got started. The memorandum from the former minister, Mr. Welch, on October 26, 1977, make very clear and explicit the Wintario principles and the conditions. As a matter of fact at the time he said he would take clubs to court if they did not fulfill the conditions.

All I'm saying is the club was not fulfilling the conditions and you sent the money, that's all I'm saying. Your principles have been bent; as a matter of fact they've been broken, period.

**Hon. Mr. Baetz:** It wasn't the case that they had not met the conditions. What was lacking at one point in time was the intent, even, to meet the conditions. Until they indicated the intention to meet the conditions—

**Mr. McClellan:** How did they get that far?

**Hon. Mr. Baetz:** Well they have now indicated, in the most formal and clear way, that they fully intend to meet the conditions set down; and they're in the process of doing it. In five years' time they may suddenly change their mind and we'll still have to get some money back, but in the meantime we're not going to wait with the final grant.

**Mr. Grande:** I really don't want to pursue this any more. I think it's very clear what is happening; it's clear to every member of this committee and I'm satisfied that you're conceding perhaps you made a mistake.

**Hon. Mr. Baetz:** There must be some static here in our communications.

**Mr. Grande:** Apropos of this, Mr. Chairman, a little while ago I put a question on



the Order Paper regarding these private clubs—23 golf and country clubs, 30 yacht and sailing recreation amenities, and 29 flying clubs which have received Wintario money. My simple question was, could you please tell me how much money you've given to these particular groups? What I get back is a two-page letter that I've had in my possession for the last three years. What's going on? Why are you so defensive in this area? All you have to say is the yacht club has received this much money; at least attempt to answer the question partly, that would be not too difficult. However you decline to do so, and I would like to know why.

**Hon. Mr. Baetz:** I think, Mr. Chairman, it must be said that if we appear to have declined to do so it is not to hide anything because we've nothing to hide.

**Mr. Grande:** Then why don't you answer?

**Hon. Mr. Baetz:** It may be administratively cumbersome to provide you with all that information; but if you wish, I have a long list of golf and country clubs—

**Mr. Grande:** I've seen that one.

**Hon. Mr. Baetz:** You've seen that one?

**Mr. Grande:** Sure; that's why I chose the 20. It came out of your announcement sometime in November.

**Hon. Mr. Baetz:** Well, that's a pretty clear—

**Mr. Grande:** All I asked you is, of these private clubs to which you've given money, tell me how much you have given to each of these clubs; as I said, the 23 golf and country clubs, the 30 yacht and sailing recreation clubs, and the 29 flying clubs: how much money have you given them? You've declined to answer that. There were a lot of other things I was asking for in that question, and I could understand if you would not give me all that mass of information; however, in terms of the amount of money you have given out, why are you holding that back?

**Hon. Mr. Baetz:** When I wanted to give you this list you said you had it.

**Mr. Grande:** Of course I have it.

**Hon. Mr. Baetz:** Are you sure you have this list? I understand from my staff that you don't have this. This is March 16, 1979.

**Mr. Grande:** I have the latest one you gave us in the Legislature when you announced the freeze. That's what I have; and that's where that 20 and 23, et cetera, came from.

**Hon. Mr. Baetz:** I'll be pleased, Mr. Chairman, to give you this latest list, for whatever use it is to you.

**Mr. McClellan:** Does that answer his question?

**Hon. Mr. Baetz:** I think it does, yes.  
[4:45]

**Mr. McClellan:** I hope the Kingston duck club is on there.

**Hon. Mr. Baetz:** Are you a member?

**Mr. McClellan:** These are all private clubs, are they?

**Mr. Noon:** There's a mixture of private clubs, and municipal facilities which are club facilities; but they are all—

**Mr. McClellan:** They all operate on a membership basis?

**Mr. Noon:** There are some membership terms, but there's also accessibility through pay-as-you-play in the case of golf clubs.

**Mr. Grande:** Then if you have that information readily available why did you decline to answer it?

**Dr. Wright:** It wasn't readily available. As the minister indicated there were considerable difficulties just doing clerical work.

**Mr. Grande:** Incredible.

**Mr. McClellan:** Is there some coding on the list that can distinguish—

**Ms. Gigantes:** Private clubs from municipal clubs?

**Hon. Mr. Baetz:** Are you referring to the secret code that is on there, is that it?

**Ms. Gigantes:** Yes.

**Mr. McClellan:** I don't know if it's secret; it may be in invisible ink because I don't see it.

**Hon. Mr. Baetz:** No secret code.

**Mr. Noon:** There is no mention of a municipality; for instance the Metro Toronto parks and recreation or the township of Ignace, on about the third or fourth page, those are municipal facilities, the others are non-municipal facilities.

**Mr. Vice-Chairman:** Do you have a question regarding payment?

**Mr. Eakins:** Yes, mine has to do with administration, Mr. Minister. I want to say that I am appreciative of what Wintario support has meant to the smaller communities in my riding; and also I want to say what a great help John Barrett-Hamilton and his staff in the office in Peterborough have been, they've just been excellent. There's no work they wouldn't go to in order to help you. I just want to put on



record my appreciation for the staff, because so often our staff don't get the credit that is due, but he is doing an excellent job. My concern is—

**Mr. Vice-Chairman:** That's the good news.

**Mr. Eakins:** That's the good news.

**Mr. Vice-Chairman:** Now for the bad news.

**Mr. Eakins:** Now we go to head office, Mr. Minister, and I wonder if you could tell me why it takes so long to process the capital grant cheques to many of these projects. I can tell you that some of the small communities are paying tremendous interest fees. I know some that are just at the limit of their credit covering the projects until your cheques come in. It's nothing for some of the small communities to have \$6,000 or \$8,000 in interest fees which they have to pay.

They call me frantically and I call your office; and we get the standard reply, another six weeks. On the next call it is another six weeks, and then maybe another couple of weeks.

I just don't think it's right, really, especially for a small village or township, to have to pay these high interest costs waiting for the cheque to be processed. I think they should have some assistance from Wintario to cover this. This is increasing the size of the project as far as they are concerned.

I wonder if you could tell me why it takes so long and what assistance you're going to give to these communities which have had to pay out large interest costs?

**Mr. Rowe:** That's after it's been approved, the dollar amount and so on.

**Mr. Eakins:** That's right; I think it's probably a standard problem.

**Hon. Mr. Baetz:** Well, Mr. Chairman, may I respond to the first part of the member's observation, the good news? I also want to have it on record that we appreciate your complimentary comments, and I can say that I have been very appreciative of the work of the staff which administers Wintario. There is a real commitment there to carry this program forward and to carry it forward very expeditiously.

On the second part, obviously I am aware of the incidents where there are delays, and where as you say small municipalities, or even private organizations, have to carry heavy capital costs and are anxiously awaiting their Wintario cheque.

I have in many instances looked into the details as to why there was the delay, but I think the person who is in the very best

position to reply here in some detail—because I think it is something we are concerned about—is either Mr. Tieman or Mr. Noon.

**Mr. Tieman:** Mr. Chairman, I'll speak to that because both the finance branch and Mr. Noon's unit, which is the capital support unit, come under my responsibility.

Since this program was transferred to my responsibility, one of our major objectives has been to speed up and improve the payment procedures; we have been working on that for four months to get both the staff and procedures sorted out.

In the last month, on almost every complaint that has come to my attention, the reason for slow payment has related to the fact that the applicant has not supplied us with the information we require to satisfy the provincial auditor, the public accounts committee or members of the Legislature who question, as it happens, when we pay them too quickly—as some members would suggest, going back to the earlier discussion. Sometimes we pay too fast, and sometimes we pay too slow.

**Mr. Eakins:** I'm speaking of the ones that are in order; where there are no problems. There is still quite a big lag there.

**Mr. Tieman:** There is a difference in perception of what is in order between the applicant and between the auditors, to whom we have to answer about the financial documentation, the fund-raising information and a whole host of other things we have to provide and have to satisfy.

I have to say that, particularly with the smaller communities, the perception of what we require and what they think we require are two different things. It does require us, with the increasing scrutiny about the payment of grants, to be very diligent about ensuring that everybody complies precisely with the information. In fact, the deputy minister and I appeared before the public accounts committee not long ago, and we were questioned about why we had paid and a whole lot of other criteria that have to be satisfied.

It is very difficult to speed up payments when you do not have the sort of information you need—agreements, information about the contract, information about all the expenditures, information about the fund-raising and other things. These things appear to be very bureaucratic and to involve a lot of red tape, and I wish we could get rid of a lot of it; but, unfortunately, people ask us to have that on file, in every file, and we are audited constantly by the

provincial auditor. It is a very difficult problem.

We are doing everything we can but, if you would bring any problems to my attention, I will certainly follow them up and find out—

**Mr. Eakins:** I've done that many times.

**Mr. Tieman:** If you will bring them to me personally, I will pursue them. Sometimes they have to do with the details of what was approved in the first instance, and a discussion of some question between Mr. Noon's staff, who are responsible for the approval process and the recommendations to the minister, and the other branch in my division, which is the finance branch, which pays them. Very often there is question about what was approved; and, of course, payments cannot be made until that basic issue is resolved. Sometimes there is a grey area.

There are often problems of cost overrun, and we find a great deal of discussion back and forth between the field consultant and the applicant, because in a large number of the projects the applicants come back with a cost overrun of one kind or another; of course, if we allow cost overruns and don't question them, the grant program will skyrocket in terms of its cost.

In any event, if you will bring them to my personal attention, I will look at each one of them and find out where the problem is; if there is no problem, they'll get their cheque.

**Mr. Eakins:** Okay. I just want to add one thing. I realize there are problems where there is a lack of information and so forth; I have had that happen. But I am speaking of cases where there have been no problems, where they have sent them in on time, but they have had to wait a long period of time.

Could I suggest, for those where there has been no problem, that you reimburse the interest they have had to pay out while waiting for the cheque, provided they have filed the correct information?

**Mr. Tieman:** Of course, I can't make that commitment—

**Mr. Eakins:** Perhaps I could ask the minister.

**Mr. Tieman:** —because the payment of interest is one that we have not contemplated.

**Mr. Eakins:** That must run to thousands of dollars, if not into millions, across the province.

**Mr. Tieman:** Inevitably on a capital cost project there are interest costs. In any

event, for almost every applicant there is some borrowing involved if you're talking about major capital programs; it is very hard to distinguish between a legitimate and—

**Mr. Eakins:** It has added greatly to their costs when, after they've had to try to raise these funds, they send the application in to you for a progress payment and they have to wait a long period of time; I've known it to go on for several months.

**Mr. Tieman:** With respect, sir, if you would bring to my attention those where you believe there should have been no holdup, it would be helpful to me to find out where the problems are in our system; then we can address the question of culpability and interest.

**Mr. Eakins:** I sent letters to Mr. Welch when he was the minister and some—not as many—on occasion to our present minister. I know Mr. Welch told me, "Yes, I know it's a problem," but nothing ever happened. One of the great problems for those communities who have everything in order and send them in is that, while they're waiting for that cheque to come back, their interest rate goes up. I know this involves quite a few thousand dollars in my own riding. While I'm appreciative for the projects, these are added costs which they hadn't planned on.

**Mr. Tieman:** I assume you are referring to a year ago, when Mr. Welch was the minister; just before he left, one of his responses to that kind of concern was to transfer this responsibility to me to see what we could do to bring the capital program under the administration division. We are working on it and, as I say, we have changed the procedures in the last four months.

I'd be particularly interested in any situations that have occurred in the last four months when we have made what we believe to be corrective actions. I am most anxious to know if those are not working as well as to ensure that the particular people who are waiting are satisfied and get the money that is owing to them and, at the same time, to find out where there may still be problems in our system of payment.

I do remind you, though, that there is a certain meticulousness that is required of us in making the final payment in particular, as you perhaps will realize from the previous discussion.

**Mr. Eakins:** Yes, some of these are progress payments.

**Mr. Vice-Chairman:** Shall vote 3001, item 1, carry?

**Mr. Grande:** No, sir.

**Mr. Vice-Chairman:** I thought I'd slip it in.

**Mr. Grande:** You probably will be able to slip it in by six, I would say.

**Mr. Vice-Chairman:** We're going to rise at five o'clock.

**Mr. Grande:** I realize that; I would say that it will probably take another hour on this. Could I make a request, Mr. Chairman, so that we're clear on our way into vote 3004, into the citizenship and multi-cultural support vote? The request is—

**Mr. Vice-Chairman:** Vote 3004?

**An hon. member:** Do it under this vote.

**Mr. Grande:** No, I don't want to go into that vote now. I'm sorry—

**Mr. Vice-Chairman:** I appreciate that; you're going to ask for some information.

**Mr. Grande:** My request is that Mr. Brian Shannon, the executive assistant to the minister, be put on as a witness.

**Mr. Vice-Chairman:** For that vote?

**Mr. Grande:** For now, because it comes under the main vote. I request that Mr. Brian Shannon, the executive assistant to the minister, be sworn in to provide some evidence. I have only one question.

**Mr. Vice-Chairman:** On vote 3001?

**Mr. Grande:** Under the main office item.

**Mr. Vice-Chairman:** Right, vote 3001, item 1. I just wanted to be certain. When would you like that done?

**Mr. Grande:** Right now.

**An hon. member:** It will only take about five minutes.

**Mr. Grande:** It won't even take five minutes.

**Mr. Vice-Chairman:** It's five o'clock; I'd have to get agreement from the committee. Is the committee in agreement? Those in favour? Opposed. There is not agreement.

**Mr. Grande:** So I'll do it tomorrow.

**Mr. Vice-Chairman:** This committee will reconvene Tuesday, April 17, following the routine proceedings in the House.

The committee adjourned at 4:59 p.m.

## CONTENTS

Wednesday, April 11, 1979

Opening statements, continued: Mr. Grande .....	S-63
Heritage conservation program .....	S-72
Heritage administration .....	S-72
Arts support program .....	S-78
Cultural development and institutions .....	S-78
Ministry administration program .....	S-81
Main office .....	S-81
Adjournment .....	S-90



---

## SPEAKERS IN THIS ISSUE

---

Baetz, Hon. R. C.; Minister of Culture and Recreation (Ottawa West PC)  
Blundy, P. (Sarnia L)  
Conway, S. (Renfrew North L)  
di Santo, O. (Downsview NDP)  
Eakins, J. (**Victoria-Haliburton L**)  
Gigantes, E. (Carleton East NDP)  
Grande, A. (Oakwood NDP)  
Jones, T. (Mississauga North PC)  
Kennedy, R. D. (Mississauga South PC)  
Kerrio, V.; Vice-Chairman (Niagara Falls L)  
Lawlor, P. D. (Lakeshore NDP)  
Leluk, N. G. (York West PC)  
McClellan, R. (Bellwoods NDP)  
Rowe, R. D. (Northumberland PC)  
Sargent, E. (Grey-Bruce L)

**From the Ministry of Culture and Recreation:**

Cruise, Dr. J., Executive Director, Royal Ontario Museum  
Noon, M., Manager, Capital Support Unit, Finance and Administration Division  
Sehmrau, U., Senior Consultant, Metro Toronto East, Field Services Branch  
Tieman, W. D., Finance and Administration Division  
Wright, Dr. D. T., Deputy Minister.











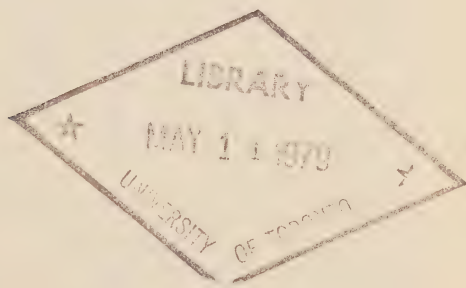
No. S-4

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Estimates, Ministry of Culture and Recreation



**Third Session, 31st Parliament**

Tuesday, April 17, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.



## LEGISLATURE OF ONTARIO

TUESDAY, APRIL 17, 1979

The committee met at 3:37 p.m.

### ESTIMATES, MINISTRY OF CULTURE AND RECREATION

(concluded)

**Mr. Chairman:** I see a quorum. Although I wasn't here, I believe that two votes were completed and we are now back to the main office on the first vote.

On vote 3001, ministry administration program; item 1, main office:

**Mr. Grande:** Mr. Chairman, before we actually begin with the consideration of the main vote where we left off, the minister has already taken under advisement that he will be reporting back to the committee in terms of the discussion that he is obviously going to have after today with the Royal Ontario Museum administration. Allegations are being made that the museum administration is using part of its operating budget for administrative purposes or for capital expenditures. Dr. Cruise was before this committee and it was unfortunate because we did not have as much information as I would have liked to have had at my disposal, at that particular time.

I would suggest that since we do not have the budget of the museum for this fiscal year before us we cannot be discussing those particular problems of the museum before we have a copy of the budget. Realizing that that particular vote has been passed—we did pass it—I would suggest to the committee that we devote at least half an hour of these estimates for consideration of the museum at a later time after the minister has had a chance to speak to the administration of the museum.

There are \$604,000 short. Somehow or other, either that money wasn't planned by the museum administration or else the minister has cut the operating budget to the bare bones and right now the museum is experiencing serious difficulties. I would suggest for consideration of the committee that we leave half an hour of these estimates so that we can deal with the museum once the minister has given us information about the discussions between the administration and the minister himself.

I would like, with the concurrence of the committee, to reserve half an hour of these estimates for a later time. That's what I'm saying.

**Mr. Chairman:** Mr. Grande, that would be a somewhat unusual procedure. As you know, today we will have roughly two and a half hours at our disposal for the consideration of these estimates. In total we have two hours and 40 minutes left. I don't know how the committee wishes to handle Mr. Grande's suggestion, but I would suggest that if we get into the position of holding over a particular vote or a particular matter for consideration at a later date, then it certainly would create problems for the committee.

What I'm saying is when a controversial item comes before the committee we just simply can't, ministry after ministry, hold over matters to a later date. It would be administratively very difficult, indeed impossible.

**Mr. Grande:** I understand that. The reason that prompted me to make this request is that I searched high and low for the museum budget for this fiscal year and I haven't been successful in locating it. So we are not in any position to talk about that vote without having a budget. Since the minister has undertaken to meet with the administration of the museum and also undertaken to report back to us regarding the fruits of that discussion, even though it's non-traditional, I suggest to you that it has happened before that a certain part of the estimate has been left over for a particular vote at a later time. In other words, what I'm saying is there are serious problems at that museum. The people who are going to be solving those problems are the minister and the administration of the museum.

However, I have questions that arise out of these public discussions that have occurred, and unfortunately I won't be able to get answers until I get the budget of the museum, and that is clearly not available.

**Hon. Mr. Baetz:** Mr. Chairman and members of the committee, I should like to remind the committee that last week I urged that the committee give all the time necessary for ROM and the other agencies that were here, and I think it will be re-

called that it was Mr. Grande himself who kept insisting that we get on with other things. There was ample time at that time to go through the budget, to review the material that was at hand, and the committee decided in its wisdom that it had more important and more pressing things to do. To reopen that particular vote and to introduce information that was here last week, I would think that would be most unusual, as you say, Mr. Chairman.

**Mr. Blundy:** Mr. Chairman, I think what Mr. Grande is asking is unusual, but I think that the situation in which we as members of this committee find ourselves in is also unusual. The seriousness of the situation at the museum was certainly not known to the extent that we are aware of it now. If we had known at the time Dr. Cruise was here as much as we do now and heard so many comments and had people approach us as we have, we probably would have spent more time delving into this matter. The museum is a very important part of our society in Ontario and in Canada, and I really think it would be worthwhile to consider the view that has been expressed by Mr. Grande. [3:45]

**Mr. Chairman:** I am certainly in the hands of the committee. I just point out that it makes it extremely difficult. It is unusual, and, as far as I am concerned, I am not prepared to entertain it unless I am directed by the committee to do so. It's up to the committee; I am just here to assist the committee.

But I think, Mr. Grande, there are a number of options one can use to pursue the matters you want to pursue. I understand your point; I appreciate your point. But I think in trying to maintain a fairly balanced flow of work through the committee, it makes it very difficult—I am sure you would admit that—from the chairman's standpoint and, indeed, eventually from the committee standpoint, if we get into that routine of dealing with matters in that fashion.

**Mr. Grande:** It probably won't happen again, Mr. Chairman.

**Mr. O'Neil:** Mr. Chairman, I would like to ask the minister when he intends to meet with the people from the Royal Ontario Museum.

**Hon. Mr. Baetz:** Yes, we had scheduled a meeting for today and it now likely will not happen until—it could be as late as next Monday. But we are still looking for common periods of time that are available to us. Mr. Hermant is a businessman in town, he is the chairman of the Royal Ontario Museum;

he finds it difficult to meet at the same moment I can—I was talking to him this morning. But it will certainly be no later than next Monday. Obviously, if we can meet before then, fine.

I can assure you, Mr. Chairman and members of the committee, that I and my ministry are prepared to examine their problem with the management and with the board of directors of the Royal Ontario Museum. We are prepared to go through it in detail to see what can be done within the limitations of constraint. I suspect we would be overly optimistic if at the very first meeting we suddenly see all the solutions. I think this is a very intricate, complicated thing. There are all kinds of questions which will have to be addressed and it may take weeks and even some months before we finally get down to making some final decisions. I think in the meantime it will in all likelihood be operation as usual at the museum.

But it's going to take some time; it's not something where you can say in an hour or even in one sitting, "Here is the way we must go and here is the kind of money you need." It's going to be a drawn-out affair. And remember we have got to go over three years on this. It is not something just for this year, but it's for next year and the year after.

**Mr. Grande:** Then is it fair to assume from what the minister is saying that the administrator of the museum did not bring these particular difficulties to the minister prior to establishing the 3.3 per cent increase you gave to the museum for operating funds? Did they not explain to him their predictions?

**Hon. Mr. Baetz:** Sure. The museum did not give to us in one package all the implications for the operation of the museum over the next 30 months. They may be doing that when we meet with them next week or later this week—chances are they will. But that kind of information we have not yet received. Sure, we had requests, as the material was here, for expanded programs which really were way out of line with the kind of restraint we are in. These were not really related to the disruption caused by the renovation and the modernization of the building. For example, they asked for a substantial increase in the number of curatorial staff, an increase that under any circumstances would have been felt to be beyond our current constraints, in line with the other demands being made on the provincial treasury.



But I can assure the committee this is not something we will be treating lightly. We will be looking at it in a very thorough and systematic way, which is going to take some time. I think Mr. Hermant, the chairman of the board, realizes this. So if you want to have a half-hour meeting on this next week, I don't think you'd get any sort of conclusive additional information that could help this committee.

**Mr. Grande:** We would certainly get an appreciation of the financial problems the museum is strapped with; that's what we would get. At this time, I am ambivalent about the situation. I don't know whether the administration of the museum is at fault in not coming to the minister and asking for the kinds of operating funds they required, and whether the museum has done the necessary planning, or whether the fault lies at the doorstep of the minister in not providing enough operating funds for the museum to function. That's why I would like, if it's at all possible, to have that half hour so the air is cleared.

I understand it is unusual. However, somebody from the other side of the table indicated that even though it is unusual, perhaps it is important enough for us to be setting that time aside. So, Mr. Chairman, I'll leave that in your hands.

**Mr. Chairman:** The minister has mentioned this matter could stretch out over a period of weeks before resolution is achieved. I am wondering, in view of that, Mr. Grande, if a few weeks down the road after the ministry has had an opportunity to meet with the ROM people once or on several occasions, it wouldn't be prudent at that point to see if there still is a problem. If there is, then I'd certainly be quite prepared to entertain a motion before the committee to have the ROM people in along with the ministry people to have a discussion about that matter.

But to do it within the confines of the estimates—save a piece of time to do it down the road perhaps in three, four, five weeks' time—I don't think would be a very wise use of the estimates time. I propose that to the member as a way to resolve the difficulty with which we are faced at the moment—balancing, as I see it, the members' concern about ROM and its budget and the minister's expressed concern that this problem isn't going to be resolved quickly, in a day or two or three.

**Mr. McClellan:** That sounds like a good suggestion, Mr. Chairman, and I recommend it to the other members of the committee. I am concerned that we not get into the Lakeshore hearings and then flip into something else in the middle of them when we

have people called in and other ministry officials are here. If you could do that I'd be quite happy to follow your suggestion, Murray, about how to deal with this.

**Mr. Chairman:** Is that agreed? Agreed.

All right, we'll continue on vote 3001, main office, item 1.

**Mr. Grande:** Mr. Chairman, as I was saying the last day, I would like to have Mr. Shannon sworn in. I have just a couple of questions for him that I would appreciate some answers on.

**Mr. Chairman:** I am sorry, Mr. Grande, I was just engaged here for a moment and I didn't hear your final—

**Mr. Grande:** If you would swear Mr. Shannon in, Mr. Chairman, I would appreciate it.

**Mr. Chairman:** I see. Here again this is an unusual procedure. I am prepared to abide by the wishes of the committee if you wish Mr. Shannon sworn.

Is that the wish of this committee?

**Hon. Mr. Baetz:** Mr. Chairman, could I make one point for the record? Obviously we are not going to oppose this, but I just wanted to register that this is a very, very unusual step you are taking here today. As far as we know, it has probably never been done that an executive assistant to a minister has been brought before a committee and has been asked to provide information under oath. We have nothing to hide, we will go along with it, but we simply want to record our strong feelings this is not in the parliamentary tradition. But so be it.

**Mr. Grande:** Does the committee have the power to do that, Mr. Chairman?

**Ms. Gigantes:** Yes, it does.

**Mr. Chairman:** To swear witnesses?

**Mr. Grande:** Yes.

**Mr. Chairman:** Oh, yes, indeed. I just make the point that civil servants and particularly executive assistants haven't been administered the oath before in committee, to my knowledge. Former employees have; I would presume it might even include former employees who were very close to ministers. But never do I recall a current civil servant or an executive assistant to the minister being sworn. But if that is the wish of the committee, so be it; I shall administer the oath if the committee wishes to do so.

**Mr. O'Neil:** I don't think this was fully understood. I know last week I myself asked that one of the other ministry officials be sworn in and I wasn't aware that you didn't do that. In other words, Mr. LeBlanc came, you swore him in and—



**Mr. Chairman:** He was a former employee.

**Mr. O'Neil:** But there is a difference; in other words, you don't usually?

**Mr. Chairman:** No.

Does the committee wish me to administer the oath?

All those in favour of administering the oath, please signify.

All those opposed?

The oath shall not be administered.

Carry on, Mr. Grande.

**Mr. Grande:** I have no questions of Mr. Shannon, Mr. Chairman.

**Mr. Chairman:** Shall item 1, main office, carry?

**Mr. Grande:** No, sir.

**Mr. Chairman:** Mr. Grande?

**Mr. Grande:** That item regarding Mr. Shannon—I guess it is done with.

**Mr. Minister,** the other day we were talking about the ad campaign for race relations and it was indicated that five companies bid for the work and the committee decided to give it to one particular company. I don't recall the name—ADI or ACI?

**Hon. Mr. Baetz:** ACI.

**Mr. Grande:** Then once that company was told the ministry or the Premier or whoever was no longer interested in doing that, then you decided to do it with in-house facilities. Can you explain why it is that before you needed a company to do it and then later you no longer needed a company to do it because you have the in-house facilities? Why didn't you do it in-house prior to the bids?  
[4:00]

**Hon. Mr. Baetz:** I don't know all the detailed considerations that took place in terms of deciding to bring forth ACI as the company to carry forward this work on our behalf. But, as I said last week and as I have said several times, when I saw the submission made by ACI in my office, at a meeting with some of our staff, I really was convinced that their proposal was far too elaborate for the kind of money we had and the very limited time frame within which we had to carry out that program.

I don't know how often I can say it and repeat it. I can assure you there were no other considerations in it. There were no telephone calls from on high, as some have suggested. I made the decision, and I made it only on that basis. I suppose ACI was putting forward a proposal. I suppose ACI doesn't say, "Maybe you have the in-house talent to do it." I don't know. But certainly the decision was mine; I made it in my office. The motivation and the reasons for it are as stated

before. I don't know how often we can go through this.

**Mr. Grande:** I suppose we will go through it as often as it is necessary to get at the heart of it.

So your staff in the information services branch did not tell you ahead of time that you had the in-house facilities and personnel to do it. Is that what you are saying?

**Hon. Mr. Baetz:** That is what one could infer. I don't know if I said that or not. But certainly, if you looked at what we had to do—we had to rent some billboards and to develop some radio spots and some throw-away pamphlets; we had in our hands the theme and the theme picture which had been produced for another campaign—taking all those things into consideration, it seemed to be a very straightforward decision that we could do it in-house; we had the staff.

As I indicated last week, I wasn't certain whether we had to have some contractual arrangement or something in the advertising world in order to get outdoor advertising. I thought maybe we had to go through an ad agency or something like that, but I wasn't sure. That is why I asked the director of administration, "Do we have to go through an ad agency?" He said, "No." It simply strengthened my feeling, why not do it ourselves?

**Mr. Grande:** But that was after the decision was made to drop the contract with ACI?

**Hon. Mr. Baetz:** The contract certainly had been developed; it had not been signed. I would have to sign it and I certainly didn't. I don't want to be repetitive, because so much is in Hansard right now about the reasons leading to this decision.

**Mr. Grande:** Are you aware, Mr. Minister, of the Social Planning Council of Metropolitan Toronto, which came down about three or four days ago, indicating that services for new immigrants are required in the suburbs, namely, in northern Toronto; that immigrants no longer come and stay within the core of the city, but they go out? Are you aware of the fact that Welcome House at one particular time had two people working in the northwest corner of the city—actually the Finch-Sheppard area of North York? When was the decision made to withdraw those two people from that particular location?

**Hon. Mr. Baetz:** To answer the first part of the question: I am certainly aware of some of some of the major features of the report of the Social Planning Council of Metropolitan Toronto. I would not take the position that some of the metropolitan elected officials have

taken. They tend to simply pooh-pooh it and say it is an exaggeration. I think I have more respect for the social planning council's professional work than that. I have known that body for many years.

In our ministry, we are certainly going to be taking a very, very close look at those sections of the report and the recommendations which deal particularly with the well-being of immigrants, questions relating to interracial relationships and so on.

Here again, I suspect that what we will be doing in response to that report isn't all going to happen overnight. We will be having a number of meetings. As Mr. McPhee can tell you, about a day or so after that report was issued, I asked him and his staff to take a close look at it; to give me some comment on it, if necessary; and, if so indicated, to arrange some meetings with the social planning people to discuss their recommendations. We are taking it very seriously.

Regarding the question about the future Welcome House being located downtown at University Avenue: I suppose in the back of your mind is probably the question which was in the back of my mind: if the problem is in the fringes, why Welcome House downtown?

**Mr. Grande:** Exactly.

**Hon. Mr. Baetz:** When one thinks through the projected plan, you have to have a nerve centre somewhere for all these services which will emanate from Welcome House. If you have to have one Welcome House in one location, the best location is still University Avenue because it is accessible by public transportation and so on.

What one could do, and what we are looking at at the moment, is—once Welcome House is set up and established—possibly having some mobile off-shoots in the outer rim.

We are, of course, continuing our rather substantial financing of any number of agencies operating in the outer rim areas. I would just like to give you very quickly the roster of these because it indicates we are aware of the problems out there.

We are giving a grant to the black education project at Jane and Finch, \$26,000; the Malton Community Council at Malton, \$15,000; Family Service Association, North York, \$15,000; YMCA of Metro Toronto, North York, \$27,872; Costi, North York, \$33,000; Jane and Finch Community and Family Centre, \$13,000; Lawrence Heights Community Action project, \$7,500.

Japanese Canadian Cultural Centre, North York, \$3,700; Community Information, Fairview at Willowdale, \$5,000; Family Service

Association, Etobicoke, \$18,000; Rexdale Immigrant Women's Group, Rexdale, \$5,000; Willow Ridge Towers Resident Association, Weston, \$6,000; Black Resources and Information Centre, \$10,700; Korean Senior Citizens' Association, North York-Scarborough, \$2,400; Friends of India Society of Scarborough, \$5,600.

So, of the total grants on this whole budget of over \$824,000, about a quarter is going to the outer rim. I certainly think the Social Planning Council of Metropolitan Toronto, even if it turns out that they're not precise in every recommendation they make or in every analysis of a social situation—and there may be questions about that—has pointed to a very basic situation where we have this peculiar phenomenon in Toronto. Because of our having saved the core, having provided a good place for middle and upper income groups to live downtown, in a sense we are pushing the immigrant and the lower income groups to the rim where there traditionally have been fewer services. Toronto is one of the few cities in North America where this phenomenon is present.

**Mr. Grande:** Mr. Minister, since you're providing a rationale for decentralization of the services that the government provides—namely, the services of Welcome House—I'm just wondering where your rationalization is in putting all the ministry has in Welcome House which is in the downtown area. That's why I'm asking you the question. I understand that a year and a half ago there were two people from the ministry working out of Seneca College, with the involvement of Seneca College, and I just would like to find out why those two people were pulled out, since the need is obviously there.

**Hon. Mr. Baetz:** Mr. Chairman, perhaps I should ask Ms. Kay Eastham to respond in detail to that question. I think really there are two reasons as to why the idea of a consolidated Welcome House downtown still makes a heck of a lot of sense. One is that even though the headlines and public attention are focused on the rim, and for good reason, there are still an awful lot of immigrants settling in downtown, and we have to remember that. The other is that the Welcome House can serve as a sort of a hub of the wheel, and provide the centralized facilities for a lot of the services being developed in the outer rim. So it's not a case of either one or the other, because if you say we should put Welcome House on the rim, where would you put it? North



York or Scarborough, Etobicoke, Malton, or Brampton?

**Mr. Grande:** I would say decentralize it and put a very small number of people to work in North York, a small number in Scarborough, a small number in Etobicoke, and so on. However, your intention is to centralize the services in one particular location, and I'm just asking you about its effectiveness, but I guess if you continue with that centralizing tendency, we'll find out next year how effective it is. While the problems exist out in the suburbs, you're attempting to solve known problems in the inner core.

On the subject of immigration; certainly this year immigration has not been as heavy as in the last 10 years. Yet for the past 10 years you kept Welcome House in the downtown area, but now, all of a sudden when these kinds of problems are emerging—and they haven't emerged as a result of the social planning council report, they have been there for a long time—

**Hon. Mr. Baetz:** They have been there for a long time, sure.

**Mr. Grande:**—for some reason you started the decentralization in a very small way then you pulled out to centralize when the problems are out there.

**Hon. Mr. Baetz:** Well, I wouldn't say we've pulled out at all. I think that by having 25 per cent of all of our funds in the outer rim it surely doesn't indicate we're pulling out, and it does make sense—

[4:15]

**Mr. McClellan:** You haven't provided core funding to any single organization or even group organization so that they can provide any kind of sustained program. You provide ad hoc funding on a year-to-year basis around particular projects, but you've never come to a policy decision that you have a responsibility to oversee, if I may use that word, the orderly development of an adequate network of settlement services—just using this particular example—and to provide core funding, not in perpetuity certainly, but at least on a stable, multi-year basis, so that people can develop adequate programs.

In the absence of that policy from the government of Ontario, we have little groups springing up, existing, living, flourishing and dying all over Metropolitan Toronto, and indeed all over the province, without ever being able to put into place any kind of adequate social service network.

You are not the only villains in the piece; all levels of government play the same stupid

game. I don't have to explain to you, as the former director of the Canadian Council on Social Development, what game I am talking about. You know it intimately. But you have an opportunity now to deal with it.

**Hon. Mr. Baetz:** As I indicated the other day, Mr. Chairman, this is the third year we have been into this ad hoc funding, and I think I went on record as saying that I personally recognize the extreme limitations of that kind of ad hoc funding. We will have to see what we can do by way of providing something on an ongoing basis, in however limited a way, but at least so they have some knowledge that they are still going to be in business the year after and so they can do a little bit of planning.

I think you would agree, though, that in the financing of these agencies one should try to remain as flexible as possible; if you don't, you end up with one well-established group in an area getting the funding when, in fact, the need has shifted, and I think you have to be prepared to move with that.

If you would like, I think you were asking about the two workers—

**Mr. Grande:** Before we do that, is that some kind of a commitment towards going to core funding? Do I correctly interpret that to be a commitment?

**Hon. Mr. Baetz:** No, I didn't say it was a commitment. It is my own—

**Mr. McClellan:** You said it was a nice idea.

**Hon. Mr. Baetz:** It certainly is my own strong bias, and I recognize the difficulties.

**Mr. McClellan:** You can't and won't support it; that's the difficulty.

**Hon. Mr. Baetz:** Let's not draw any conclusions on that.

**Mr. Grande:** Who makes those commitments, if not the minister? Who gives policy direction, if not the minister? I am just asking.

**Hon. Mr. Baetz:** You yourself know very well that these kinds of funds come from the central pot. There are all kinds of demands on those funds; you have to balance it off with other needs and take it from there.

Anyway, I hold no brief in favour of ad hoc funding as contrasted to ongoing core funding. But you and I know that, once government is into core funding, you are in for a long marriage; and sometimes you are into something you wish you were out of, and should be out of, but it is extremely difficult to change.



**Mr. Grande:** You are retreating now.

**Hon. Mr. Baetz:** I am not retreating. I am giving you some of the pros and cons. It isn't all positive.

**Mr. Grande:** Perhaps Ms. Eastham can answer that question regarding Welcome House and the two people, I understand, you had out in the northwest corner who now have been pulled out.

**Ms. Eastham:** I think your question was in relation to the Seneca Jane Project. This is a multi-service centre run by Seneca College. The ministry generally has been involved with providing consulting and financial advice in getting the centre off the ground.

About 18 months ago, precisely because of the recognition of the needs in the outer rim, we arranged with them, on a one-year pilot basis, to lend counsellors from Ontario Welcome House to provide counselling in different languages. It worked out to four days a week; so one day, you would have somebody there who spoke Italian and the next day somebody who spoke Greek, and so on. The idea was that this could be a precedent in other outer rim areas. We had similar discussions with the Etobicoke social planning council.

Unfortunately, that particular pilot project didn't work out; there were various delays in actually opening the Seneca Jane centre. Also, we found—and we did not control the publicity—that the publicity for the centre was unilingual; it was only advertised in English. So there weren't that many people speaking other languages who actually came to the centre. We found that the volume of counselling just didn't work out. The counsellors were sitting there idle.

As you know, recently we have had an extra burden at Welcome House with the Vietnamese refugees. For now, the counsellors have been pulled back to Ontario Welcome House where the greatest need is. The question of whether the arrangement will continue is still open to negotiation. There hasn't been a permanent withdrawal but, for the moment, in terms of meeting the needs down at Welcome House, the counsellors have been withdrawn.

**Mr. Grande:** How are plans going for the Etobicoke social planning council and the Scarborough one? Have those plans been dropped as a result of this experience?

**Ms. Eastham:** No, they are still in the discussion stage. We had a series of meetings with a variety of groups working with immigrants in the Etobicoke area and discussed with them the different types of support that

the ministry could provide in terms of grants, training, consulting, and what have you. One of the suggestions we made to them was that they could negotiate with us a similar arrangement to Seneca Jane. Staff from Welcome House went out to meet with members of the social planning council, but they haven't yet got back to us with a concrete proposal on that. We are certainly open to those kinds of arrangements in the outer rim areas.

**Mr. Grande:** I just don't know how to understand that particular policy which says that the need is in the outer rim areas and the suburbs and yet we are going to be centralizing pretty well all our resources from the Ministry of Culture and Recreation in Welcome House which is downtown. You are going to have to deal with that in a real way. The social planning council, from my reading, talks about few services in Metro suburbs, especially for recently arrived immigrant women. You have to address that question.

If you centralize your resources in one particular place, I think perhaps your ability to deal with the problems in the suburbs is going to be limited. I hope it is not going to be that way but, as I say, we will take a very close look at how those particular needs are met from your ministry and we will come back to you next year.

Regarding the core funding, I would certainly urge you to get into that and begin to give some kind of a permanency to services that are badly needed. As the member for Bellwoods says, you understand the problem; it is now up to you to act. You are the top cat right now in that ministry and it is your responsibility to do that.

**Mr. McClellan:** Is anything taking place within the social development policy field as a whole with respect to the organization and delivery of social services? Ontario has never had the equivalent of a Seeborn report or a Castonguay-Neveau commission. I think we suffer from that lack, from the fact that we have never had a serious examination of the multiplicity of actors in the social service sector. You're in there, Community and Social Services is in there, Health is in there, Education is in there and the voluntary sector is in there. Local municipalities, regional municipalities and umpteen zillion branches of the federal government are all doing this macabre dance around social problems and social services, none of it co-ordinated, none of it integrated, and none of it coherent.

I don't have to tell you this; you have lived with it for years and years. My impression is that despite the fact that we have a social policy secretariat and a number of relatively—and I use the word "relatively" advisedly—

knowledgeable ministers in each of the portfolios, the problem is ignored. The problem isn't being seriously addressed. You're not going to be able to solve it. If you move to core funding, at least you will rationalize one of the more absurd features of a little sector, that is to say, services for new Canadians, by giving some measure of stability. In the absence of any kind of government commitment to reorganize through decentralization of the social service delivery system, and to provide some coherent stability with respect to funding, we're never going to be able to address the kinds of problems the social planning council was raising for the umpteenth time.

**Hon. Mr. Baetz:** Mr. Chairman, at the risk of appearing to be passing the buck, which I am only doing partly, I think the provinces were coming close to being able to plan and to put in place and to implement their social service programs with the funding envisaged under the social services legislation of the federal government where they are going to give the provinces block funding. As you know, that hasn't happened. I think that has been a very unfortunate development. I think it's something for which the provinces should keep pressing.

**Mr. McClellan:** It hasn't helped us very much in health care.

**Hon. Mr. Baetz:** We're talking social services.

**Mr. McClellan:** Yes, I said that deliberately. I don't see that as any kind of an answer at all, Reuben. If you had another \$50 million with total discretion as to how you as a government were to deal with it, I don't have any confidence you would begin to address the kinds of concerns I'm raising.

That speaks to the availability of resources. It doesn't speak to the will of the government to reorganize the social service delivery system so it makes sense, so there's a social planning component in our public planning processes across the province. You guys aren't dealing with that. You're not dealing with that at all. You're each in your own little world, in your own little empire.

There is a Feiffer cartoon in the latest issue of the Ontario Welfare Reporter which, I'm sure, you saw. It's about the bureaucrat throwing dollars at problems. The little kid asking him why he is throwing dollars at problems. He said, "If I throw the dollars at the problems, then they'll go away."

**Hon. Mr. Baetz:** I don't argue with your objectives at all. I think we see eye to eye on that, but I think it can be deceptively simple to say, "You can draw that master

plan and you can fit it into place." Quebec tried it and they are having all kinds of problems, as you know. They've regionalized and they had all their information referral centres set up nicely. I've seen those models and I've said, "That is the greatest thing to happen to social development."

**Mr. McClellan:** Everybody has it, sure. You say that about Quebec and people sneer at the implementation of the Seeborn report and they thumbed their nose at the human resource boards, but we haven't gone to square one.

**Ms. Gigantes:** It's made a big difference in Quebec.

**Mr. McClellan:** Having trouble with your implementation is an entirely different thing than wallowing in your old stew.

**Hon. Mr. Baetz:** I wasn't going to mention the human resources development boards but you did. It's another example of where it looks good on paper but when you try to translate it into programs it's not so good, but that doesn't take away from the objective. We see eye to eye on the objective.

**Mr. McClellan:** No, we don't at all. You are locked into each ministry playing its own game. You're just as locked into that as is Mr. Norton, as is Mr. Wells, as is each of your colleagues. They all play their own game. The feds all play their own game. The municipalities all play their own game and the people suffer from the absence of any coherent delivery system. Anyway, I always make this speech, as you well know, Mr. Chairman, at this point in the estimates.

**Mr. Grande:** From the very beginning, the motion passed to bring Mr. LeBlanc before this committee indicated certain materials were to be tabled. I wanted to know if the minutes of the interministerial committee on multiculturalism are tabled and if we could have copies of that.

[4:30]

**Hon. Mr. Baetz:** If I may respond to that, Mr. Chairman, perhaps this is the time to list those documents that I agreed to table during the debates that took place last week.

1. Copies of my responses given in the Legislature on December 13, 1978, concerning the Kensington Arts Association.

2. Copies of the news release issued by the Ontario Human Rights Commission on March 27, 1979, concerning a recent publication of the Metropolitan Toronto Police Association.

3. Copies of a memorandum requested by Mr. Grande, dated February 23, 1979,



from Mr. R. W. McPhee, executive director, citizenship division, to staff of that division, concerning the establishment of a special multicultural outreach committee.

4. Copies of a memorandum, also requested by Mr. Grande, dated March 19, 1979, from Mr. R. W. McPhee to Dr. D. T. Wright, deputy minister, which outlines the progress on the multicultural outreach project.

5. Copies of the following material relating to the interministerial committee on multiculturalism: (a) terms of reference; (b) minutes of the meetings held on June 1, 1977; June 10, 1977; August 17, 1977; October 25, 1977; December 2, 1977; February 13, 1978; March 21, 1978; May 4, 1978; (c) an article from Topical concerning an exhibit, entitled Multicultural Profile of Ontario and dated April 28, 1978; (d) Civil Service Commission staff development calendar, 1979-80, outlining the cross-cultural communications course; (e) minutes of the Ontario Advisory Council on Multiculturalism, 38th meeting, February 16, 1978; and (f), in answer to Mr. Grande's question last week about what the ministry has done with regard to the race relations campaign, I am providing each critic with material that has been developed in-house.

I think that covers the requests made for the tabling of documents.

**Mr. Grande:** Except, Mr. Minister, are you suggesting that the last meeting of the interministerial committee on multiculturalism was in May 1978? That's where you ended.

**Hon. Mr. Baetz:** That is the information I have. That's the last set of minutes available to us for filing. I don't know; maybe I could have that confirmed by a staff member.

**Dr. Wright:** As far as we know. We believe this to be a complete set of minutes. Maybe Mr. McPhee could respond.

**Mr. McPhee:** Mr. Minister, we believe May 4 was the last meeting of that committee.

**Hon. Mr. Baetz:** In 1978?

**Mr. McPhee:** That is our understanding. But the question should be put to Mr. Cook.

**Mr. Grande:** Is that committee disbanded?

**Hon. Mr. Baetz:** No.

**Mr. Grande:** Do they have one meeting a year?

**Hon. Mr. Baetz:** Obviously it is not exactly a great beehive of activity either. If it's supposed to develop a political thrust, it's not doing very well.

**Mr. McClellan:** This is the one the famous Mr. Cook is providing such excellent leader-

ship to, I assume. He's a real dynamo, I guess.

**Mr. Grande:** May 4, 1978? Incredible. Are those people doing another job? Are they performing other duties?

**Dr. Wright:** Mr. Chairman, none of the people on the committee representing ministries would have relinquished any of their other responsibilities to participate in that work.

**Mr. McClellan:** Let us know when the committee meets again.

**Ms. Gigantes:** You don't need that committee. What do you need the committee for any more? Cook co-ordinates it in the Premier's office.

**Mr. McClellan:** Cook could tell them occasionally what they are supposed to do, I suppose.

**Dr. Wright:** The terms of reference are clear. As I think it was indicated last week, its primary purpose was to create some consultative processes between the ministries. To a degree it can be argued, at least partially, that the committee has not needed to meet because of the degree to which some of the people on it have come to know of each other's existence and to co-operate between our ministry and the Ministry of Education, and so forth.

**Mr. McClellan:** Was there discussion at the committee of the reduction in the budget of the heritage language program? Is that an issue that went to the committee for joint input?

**Dr. Wright:** The committee didn't meet. I think you would have to ask the representatives of the Ministry of Education when they appear for their estimates.

**Mr. McClellan:** That wasn't something that to your knowledge at least was brought to that committee for deliberation?

**Dr. Wright:** No.

**Mr. McClellan:** So much for co-ordination.

**Mr. Grande:** So much for the committee on multiculturalism, let me tell you. It is obviously dead. And that is your topmost priority in your ministry?

**Hon. Mr. Baetz:** That is not my priority. That is not even in my ministry.

**Mr. Grande:** That is just what you said.

**Mr. McClellan:** Whom does it report to? Social Development?

**Ms. Gigantes:** The Premier (Mr. Davis).

**Hon. Mr. Baetz:** Mrs. Birch, I guess it is.

**Mr. Grande:** We will have to ask the Premier when his estimates come up.



**Hon. Mr. Baetz:** Or Mrs. Birch. We are far more active than that.

**Mr. Grande:** But you did say the multiculturalism is the top priority in your ministry.

**Hon. Mr. Baetz:** Indeed it is. We are carrying out a very good program there which will be stepped up.

**Mr. Grande:** And yet this committee, the end-all and be-all, according to the Premier, started to function in May 1977. By May 1978 it looks like it has finished its task.

**Hon. Mr. Baetz:** It may look at what is going on in the Ministry of Culture and Recreation and be so satisfied that the work is going forward that it has decided to become somewhat dormant.

**Mr. Grande:** The Premier decided to put him on another task, in other words. We will get the minutes. When we get to financial services, I have some questions but for now I relinquish the floor.

**Ms. Gigantes:** We are just so fascinated by this document that I wonder if we could take a couple of seconds to look at the minutes of that last meeting and see where they found such satisfaction with their interaction they decided there was no need for a meeting.

I guess this whole question of whether or not they met was the question Mr. LeBlanc was referring to when he said he had been approached several times by Mr. Cook and asked whether the calling of a meeting of the committee would seem to be in order. He always encouraged Mr. Cook to hold meetings and prepared a couple of tentative agendas and so on. This is what would be in question, whether or not there would be a meeting since May 1978.

**Hon. Mr. Baetz:** Since that committee reports to a different minister, I think this committee should direct its questions to that other ministry.

**Mr. McClellan:** When the chairman at the initial meeting outlined the purpose of the committee as an internal structural function—I have trouble with gobbledegook—whereby all government policies relating to multiculturalism can be co-ordinated and accentuated, I assume from what you have said to us, just so that we can take this information to the appropriate minister at the appropriate time, that that is not what has been happening with that committee and, as a matter of fact, that has not been happening. Let the record show that the minister refused to answer the question.

**Hon. Mr. Baetz:** I have just been advised that there was a meeting on July 14, 1978.

**Dr. Wright:** The minutes of that are in the sheet you have, I believe. It is just that the list the minister read from was incomplete for the last item.

**Ms. Gigantes:** I am looking at the minutes of the 38th meeting of the Ontario Advisory Council on Multiculturalism in which there is a report on the interministerial committee on multiculturalism. This advisory council meeting was in February 1978. There is a long description of the role and responsibility of the interministerial committee. It says at page 11 of that minute that the interministerial committee members, all of whom are civil servants, meet approximately once every six weeks. Did you become aware as the minister of any change in the structural operations of that committee?

**Hon. Mr. Baetz:** I think Mr. McPhee could fill in the committee on that.

**Mr. McPhee:** Mr. Chairman, I'll ask the acting director of the multicultural development branch, Mr. Diakowsky, to speak to it because I think that we can only account for the time of our staff on that committee. As I think the record already shows, the permanent delegate was Mr. LeBlanc. Two other staff participated in subcommittees, one to develop a cross-cultural training program for the Civil Service Commission. There is such a program, as I understand it, at this time. In fact, I attended the first one. The other dealt with an exhibit in the Macdonald block. I think Mr. Diakowsky can perhaps speak in a little more detail about these.

**Mr. Diakowsky:** The representative from our branch on that subcommittee was Mr. Thad Rachwal, who worked with representatives of other ministries and with Mr. Cook to develop an exhibit which was held at the Macdonald block to show civil servants primarily what the various ministries of the government were doing in the multicultural field. As a matter of fact, that is the exhibit on which there is a story in *Topical*, which I think you have been given.

**Mr. Grande:** I think this is becoming a joke. I guess the deputy minister would know more about this than the minister does. Does the minister realize that this particular meeting with the Ontario Advisory Council on Multiculturalism was held at the request of that council and that they had asked that interministerial committee to meet with them for three or four months because they didn't know what on earth they were doing?

The Ontario Advisory Council on Multiculturalism didn't know what this committee

was doing. This was the last meeting, once the advisory council found out what they were about. It's incredible.

**Hon. Mr. Baetz:** I really think that these comments and questions should be directed to the Provincial Secretary for Social Development (Mrs. Birch). It is more directly related to that particular committee.

**Ms. Gigantes:** May I ask if Mr. LeBlanc did not make it known to his superior that there weren't meetings? Did he express frustration over that and was that frustration then expressed to the minister?

**Mr. McPhee:** Yes, Mr. LeBlanc was most unhappy with the committee.

**Ms. Gigantes:** Was that unhappiness communicated to the ministry?

**Mr. McPhee:** This ministry has consistently taken the position that that particular committee should report to this ministry.

**Ms. Gigantes:** That wasn't the question I asked, but it's an interesting answer.

**Mr. McPhee:** That's an expression of our unhappiness, which I am candidly admitting.

**Ms. Gigantes:** Your unhappiness as a public servant.

**Mr. McPhee:** Mr. LeBlanc reported his unhappiness to me.

**Ms. Gigantes:** Was that unhappiness and the unhappiness of your ministry communicated to your minister?

**Mr. McPhee:** Yes, it was.

**Ms. Gigantes:** And what did you do about that unhappiness, Mr. Minister, when it was communicated?

Interjection.

**Mr. McPhee:** I can answer that too.

**Ms. Gigantes:** I'd like to hear it from the minister.

**Hon. Mr. Baetz:** Go ahead.

**Mr. McPhee:** Our minister has supported us in this ministry's submissions on the throne speech and in other areas, that that committee should indeed be relocated in the Ministry of Culture and Recreation.

**Ms. Gigantes:** What are the chances of that, Mr. Minister?

**Hon. Mr. Baetz:** It depends perhaps on your committee's discussion and debate with the Provincial Secretary for Social Development. I don't know, it could be.

**Ms. Gigantes:** I suppose we might want to clear up the matter of the goals your ministry sees for itself, in political terms, before we would be content to see that, inadequate though the past action has been.

**Mr. Grande:** Mr. McPhee, did Mr. LeBlanc, before his resignation, ever discuss with you his ambivalence on the new direction the ministry was taking? I am just taking his own words. Did he ever speak to you about those things and about his concerns with the new directions? Because the minister, in his opening remarks, suggested that he was very sorry Mr. LeBlanc did not talk to either you or to the minister. Did he ever express any concerns to you?

[4:45]

**Mr. McPhee:** Mr. LeBlanc was very careful to state that he did not in any way discuss his plan to resign with me. I also stated last week that when there is a change in administration in any ministry there is a great deal of nervousness and stress during the period of change. I stated for the record at that time that Mr. LeBlanc had my full confidence; and I shared many of my negative feelings with him, as he did with me. However with respect to his allegation, you saw, it was tabled, his memo of the very week in which he disappeared, which indicated his full participation and his views that in his judgement certain things should go into Welcome House and certain other things shouldn't. That was on the Monday. On the Wednesday, he fully participated in a flip-chart exercise in my office as we drew up an organization model, which I don't think has been circulated as yet because I think I have the only copy. Yours is not up to date, Mr. Grande.

**Mr. Grande:** Perhaps you could provide me with an up-dated copy.

**Mr. McPhee:** He then participated, on Thursday, in briefing Mr. Baetz on race relations. I attended that meeting with Mr. Baetz and reported back fully to Mr. LeBlanc on Friday. Then Mr. LeBlanc and I had a friendly chat on Saturday, and he said: "I'll see you Monday, Bob." That's the last I've heard from Mr. LeBlanc.

**Mr. Grande:** I know he stated he did not talk to you about his resignation; and he felt very strongly about that, he did not want to implicate any of the staff in the multicultural development branch on his resignation. My question was, prior to resigning did he speak to you at any one particular time about his concerns, about the political direction the ministry was taking? That's all I'm asking.

**Mr. McPhee:** Mr. LeBlanc did not use the term "political direction." He stated, "concerns any group of managers"; and this would have happened had there not been a



change in administration in the MBR, which as you know succeeded the MBO, which succeeded the PPBS—it took me some time to learn these terms. In my MBR of last year is a plan to review the multicultural development branch this fiscal year. We are actually behind time.

The first year there was the review of the translation bureau, which resulted in its reorganization. The second year the review was of the native community branch. This year the multicultural branch was to be the subject of review. Mr. LeBlanc indicated many fears and many concerns, because I frankly have a bias towards the sharing of resources. I see publications being done in one corner of the multicultural development branch, and not many feet away I see people such as Lillian Butosky and others who have given 15 or more years' service doing much the same kind of work with another wall around them called the newcomers services branch. I see one part-time researcher in MBD. I see newcomers services get their first researcher.

There's no question that I had unleashed a review of that branch under Mr. Welch and Mr. Johnston last April; and I've requested Mr. Tieman to have the ministry's audit people audit that branch this summer. This comes before Mr. Baetz or Mr. Wright, or the so-called new political initiatives were ever thought about, if they have in fact been thought about to this date.

**Mr. Grande:** I have one more question; I am sorry, but Mr. McPhee was not at the microphone when I ended.

Was the ethnic press review going on? The other day you put it in the context of this being an unborn baby and trying to tell the colour of the baby's eyes before the baby was born. Was the ethnic press review being done prior to the development of this outreach program? Is it being done right now?

**Mr. McPhee:** I am not attempting to be facetious; but if you use the word "ethnic" in the sense that the multicultural policy of the government intended, that is of ethnics, every day the Globe and Mail, the Sun, the Star, as well as a wide variety of other Ontario English-language papers and a wide variety of Ontario French-language papers, arrive in the offices of the multicultural development branch—and have done so since I have arrived; correct me if I am wrong, but I believe my colleague Mr. Diakowsky felt this should be broadened somewhat to other groups in this province.

**Mr. Grande:** Let's get away from labels. Are the third language newspapers, published either weekly, daily or monthly, reviewed within the ministry; and did that review start prior to the last three or four weeks?

**Mr. McPhee:** Not at the taxpayer's expense. Mr. Diakowsky might want to comment on that.

**Mr. Diakowsky:** There was one trial or model attempt made. When Mr. McPhee says not at the taxpayers' expense, it is because I paid for the newspapers myself; and I have been negligent, I haven't claimed for them. It was last fiscal year and I think I am going to be out \$4.50.

There is no review of the third language press being done. One attempt was made to see what could be done, but no review is being done.

**Mr. McPhee:** One of the active considerations we have at the moment is to be able to use, in addition to their present duties, the multilingual staff, that is the non-French-English staff of the translation bureau, to review the third language press as the two official language press has always been reviewed. I might also say the native community branch has received and reviewed the native press for many years.

**Mr. Grande:** Are you making the distinction between the press clipping services?

**Mr. McPhee:** No. We found the press clipping service to be most inadequate. We tried it for a month and cancelled it.

**Mr. Grande:** Is it something else, another mechanism developed within the Ministry of Culture and Recreation?

**Mr. McPhee:** I am not sure of your question, other than what I just answered. We are attempting, and hope to do, a much better job of monitoring Ontario's third language press than we have done in the past.

**Mr. McClellan:** We assume that service will be available as a public service to the members.

**Mr. Diakowsky:** I believe the minister made that commitment.

**Mr. McClellan:** Now that we have seen your major vehicle for co-ordinating your multicultural policy is dead as a dodo, what vehicle do you have to fill that gap, aside from your speeches which will be disseminated assiduously by all sectors of the ministry?

**Hon. Mr. Baetz:** There are other vehicles, and perhaps Mr. McPhee would want to review the activities.



**Mr. McClellan:** I don't want to ask Mr. McPhee to be accountable for a major vacuum in the government's overall multicultural policy. This committee was announced by the Premier (Mr. Davis) in May 1977, when he made his major statement on multicultural policy. He laid down the three components of the policy; that the committee would, and I quote the Premier:

"The committee will give us, as a government, a totally new and effective vehicle by which all government policies related to multiculturalism can be co-ordinated and accentuated in the best possible way."

So I ask you now, as the minister responsible for multiculturalism, what is the vehicle that brings co-ordination out of, I think 10 government ministries involved in multicultural programming? Or is there a complete absence of any co-ordinating mechanism? And if that is the case—and it obviously is the case because your committee doesn't function at all; it hasn't met for eight months—

**Ms. Gigantes:** Mr. Cook.

**Mr. McClellan:** Leaving aside the late Mr. Cook, what do you propose to replace the committee with; or has the government not come around to dealing with this nasty little problem yet?

**Hon. Mr. Baetz:** I think it more appropriate that that question be directed to the ministry responsible for that committee.

**Mr. McClellan:** You disclaim any responsibility for that co-ordinating function? That's fine. I am quite happy to take your abdication of any kind of central authority and deal with people who are more consequential.

**Hon. Mr. Baetz:** That was several years ago. It may be that quite a few of the ministries, including my own, have developed their programs. Maybe this kind of centralizing or co-ordinating mechanism is no longer as direly needed as it was at one time.

**Mr. McClellan:** I've got news for you, Rudy.

**Hon. Mr. Baetz:** That is a question I think you should direct to the minister responsible.

**Mr. McClellan:** Well we know who isn't responsible, don't we, and that is you.

**Hon. Mr. Baetz:** I am not responsible for the interministerial committee; I am responsible for multiculturalism in my ministry.

**Mr. McClellan:** Right. It gets back to the point I was making earlier. You are no more prepared to deal with this than you are with anything else.

**Hon. Mr. Baetz:** I think we made a rather strong recommendation; that is one thing that might happen to that committee.

**Mr. McClellan:** Right. We will come back to this in another set of estimates.

**Ms. Gigantes:** I would like to raise, under the main office vote, the question of policy related to this ministry's support of libraries in Ontario. I would like to ask the minister what the policy is, because a brief review of funding from this ministry for libraries in Ontario indicates that the province is withdrawing support. That seems to be the policy direction.

**Hon. Mr. Baetz:** I think Mr. Roedde is here, I saw him a moment ago. I believe he could respond to that question in much more detail.

**Ms. Gigantes:** Mr. Chairman, I would be quite happy to talk to Mr. Roedde, but I would like to get a statement from the minister concerning government policy for support of Ontario libraries.

**Hon. Mr. Baetz:** I will refer you to the book.

**Ms. Gigantes:** I have been looking at the book. I look at figures of funds the province has been providing to libraries, starting back in the fiscal year—if we just go back to 1977-78, we see estimates of transfer payments to Ontario public libraries of \$24,762,500. The actual expenditure in that year was almost \$1 million short of that.

[5:00]

If we move to the estimates for the fiscal year 1978-79, the estimated budget is lower. The estimated funds coming from the province have been decreased from the previous fiscal year by \$219,700, and the actual expenditure is even lower than that. The increase in actual funding from the province to libraries in the province between the 1977-78 fiscal year and the 1978-79 fiscal year was a whopping 1.8 per cent. If we move then to the figure for the fiscal year 1978-79 and compare that to the amount in estimates before us now, we see a reduction in the increase. The province is now estimating that it will increase the amount by 1.65 per cent. Given the record over the last three years, the estimates are always larger than the actuals, as the ministry seems to be able to save money on these grants.

Looking at those figures, and looking at the decision this year that there will be an absolute decrease of \$252,000 in the amount allocated through Wintario non-capital grants to libraries, I feel all this adds up to a withdrawal of provincial support.

**Hon. Mr. Baetz:** This is a highly involved question. It was for that reason I suggested that—

**Ms. Gigantes:** Is it your policy to withdraw support?

**Hon. Mr. Baetz:** If you were to look at the statistics published annually under the rubric of public libraries statistics in the Ontario Library Review, which are based on the Statistics Canada questionnaire, they indicate that in the decade 1968 to 1977 the average rate of increase in provincial funding was 16.3 per cent and that has been greater than the rate of increase in local funding.

**Ms. Gigantes:** That is 16.3 per cent per annum?

**Hon. Mr. Baetz:** Or a total public library expenditure of 15.7 per cent.

**Ms. Gigantes:** We are into a new decade now and there seems to be a withdrawal of provincial funding.

**Hon. Mr. Baetz:** It's not a withdrawal. You might call it a flat line.

**Ms. Gigantes:** A 1.8 per cent or 1.65 per cent increase can hardly be called a flat line. That's a line that has sloped down.

**Hon. Mr. Baetz:** That doesn't take into account other ways and means of assisting libraries, including Wintario.

**Ms. Gigantes:** Your non-capital grants from Wintario are going down this year. In 1978-79, they were \$2,252,000. The estimate for this year is \$2 million. They have gone down 10 per cent. Don't you call that a withdrawal?

**Hon. Mr. Baetz:** I really would like to have Mr. Roedde cite some of the statistics, which I know he has, to provide us with a more accurate picture as to our base of funding.

**Mr. Grande:** Run and hide; that's what it is.

**Hon. Mr. Baetz:** Run and hide? No, I wouldn't say so.

**Mr. Chairman:** Mr. Roedde, can you throw some light on the situation?

**Mr. Roedde:** Mr. Chairman, I have some statistics here which indicate that over a 10-year period, 1968 to 1977, the rate of increase in provincial funding was greater than the rate of increase in municipal funding. The percentage increases were quite substantial. The provincial grant increased at an average of 16.3 per cent per annum over the 10-year period and the municipal funding increased at an average of 16 per cent.

This substantial increase in Ontario funding over a 10 year period means—

**Mr. McClellan:** Mr. Roedde, did you say 16.6 and 16? Is that what you are saying?

**Mr. Roedde:** I said 16.3 and 16. But I was going to say that this period is from 1968 to 1977. During that period Ontario accounted for more than half of the provincial funding of public libraries in Canada.

In 1978 and 1979, the rate of increase was very modest and I think the assumption has been that many programs in the ministry have not been funded at all and that funds would be allocated there. For instance, some other programs, such as art gallery grants, are of assistance to libraries. There were no art gallery grants until two years ago. These grants were instituted as a program and the funding comes out of the arts support branch. If the art gallery is under the public library board, this grant is paid but it's paid not to a library as a library, but to a library with an art facility.

In other words, I think we have seen a moderating in provincial support of public libraries in the last couple of years and I don't suggest that this doesn't create any problems. It does. It requires careful setting of priorities in the various local and regional libraries and there are some very tense moments at times as libraries decide whether to reduce the hours of branches or reduce allocation for book collections and film services and so on.

I don't suggest there aren't any problems but I do suggest that the ministry's funding of other programs has assisted the libraries to some extent, involving them in cultural programs through Outreach Ontario, funding for which, of course, doesn't come under the libraries vote but comes under the arts vote, and the Experience program of assisting in the employment of students. In other words, the library vote is not an isolated funding, nor is the library an isolated institution but rather a part of the mosaic of cultural and recreational services within the community, so that some of the funding which has become available within the ministry has gone to other programs which may or may not involve the libraries.

**Ms. Gigantes:** Essentially what that means to me, Mr. Chairman, is that there is a withdrawal of provincial support for the libraries of Ontario because we are moving from a decade where provincial support matched municipal support—exceeded it by 0.3 per cent a year, mind you—to libraries and the level was about 16 per cent increase per year. We are now into a period where



quite clearly the level of funding, through the transfer of payments, which is the core funding for Ontario libraries, has dropped to the 1.8 per cent and 1.65 per cent levels. Wintario money is being cut absolutely. The estimates between two fiscal years actually dropped and the results of that kind of withdrawal are pretty grim. I know they are in my locality and I am sure that the minister does too.

I would like to draw to the attention of the committee an article that appeared in the Toronto Star on the ninth of last month which is a very thorough review of the difficulties now facing—in fact, difficulties nothing, the crisis facing—the Metro Toronto library and it provides perhaps the largest example of the crisis, because it is a very large library but it's a pretty clear indication of what this withdrawal of provincial funding is going to mean.

The Metro library cost \$11,400,000 to run in 1978, of which the province kicked in \$1,300,000. What is happening in that library—it has moved to new facilities, larger facilities—is that it has been able to increase its service to the public in this area by leaps and bounds.

In 1976, when it was located at College Street, 568,039 people come to the building. With the move to the new site, that library was serving 1,445,315 users—almost a tripling of service to the public in a two-year period and certainly an awful lot more use of the library's volumes. At the same time, the library quite clearly is in a crisis that threatens to bring it to an absolute dead halt.

I will make the points outlined here in the article:

"Staff morale is deteriorating steadily, with no sign of relief, as workloads double and triple." They are doubling and tripling and those figures indicate it.

"Tensions are building between management and the four Metro library locals of the Canadian Union of Public Employees, with negotiations under way now for new contracts." That, with 1.65 per cent and 1.8 per cent increases over the last two years.

"Management personnel, especially regional director John Parkhill, are beginning to find their jobs are hotseats, not the cool, cushy sinecures some in the public think." I don't think they are.

"Public service inside the library is deteriorating steadily, with signs that the future could be worse—lineups at inquiry desks; delays in getting material; rushed help, and increasing helplessness in orienting people who can't help themselves." If you're going

to serve 1,445,315 people, they are going to need help in getting oriented.

"Telephone service is bogging down at busy times, with more and more callers being given short shrift or simply told to come down in person and 'do it yourself.'"

"Simple but time-consuming tasks such as reshelfing or checking already shelved materials for items misplaced by users are being sacrificed. Items take hours, days, or, in the case of some improperly shelved books, months to get back into circulation.

"Caps are beginning to appear in the massive book and periodical collection as expertly trained staff are forced to spend too much time on simple service tasks and too little time searching for choice new items to buy.

"Some new items, including those in high demand, are on the shelves but are 'lost' because filing of catalogue cards is backlogged and there's no record the items are there.

"Inadequate supervision means that vandalism . . . is increasing, although officials are uncertain by how much.

"The physical quality of the collection is deteriorating because there's no time to check for vandalism or natural breakdown through frequent usage.

"Several special collections—in fine art, theatre and music—are accessible only six hours a week because no one is available to supervise their use.

"Donations of historical material, which have enriched the library's priceless special collections, are now often refused outright because the staff cannot afford the time to cull them for good items and organize them for public use.

"The new building requires better maintenance than the old just to keep it in normal, good condition, but the budget squeeze means taking shortcuts which will cost bigger money in future years as carpets wear out and other equipment falls apart.

"The building is always too cold, every season of the year; at the same time the much more complicated new building needs more maintenance staff (none are being added) and adjustments to improve conditions such as temperature are difficult."

That's a pretty grim litany of what's happening to a rather magnificent library with pretty dedicated staff. I think the enthusiasm of the people who run that library is something that people in Ontario, as a whole, can look to as a model; that is, in terms of service to the public and a real commitment to having a library fulfil the community role it has had in this country and which it



should continue to have. We see a library such as this one, able to triple its service to the public but obviously crumbling under the pressure of normal inflationary facts. Now there's the absolute withdrawal—I have to call it that—of provincial support: a drop from 16 per cent per annum in terms of increases to 1.8 per cent and 1.65 per cent. Are you aiming for zero?

Hon. Mr. Baetz: Indeed not. No.

Ms. Gigantes: What are you aiming for? [5:15]

Hon. Mr. Baetz: No doubt some of the conditions prevailing at the library in Toronto as reported by the Star are correct. I don't think there's any argument about that at all. I think it is overly simplistic, however, to say the total answer is simply more and more provincial funding. I think there are many factors that have to be taken into consideration. Increased user fees could be one.

Ms. Gigantes: Is that your idea of a library?

Hon. Mr. Baetz: Increased local support, sure. Why not? Increased support from the private sector.

Ms. Gigantes: Why don't you tell people to go to bookstores instead and shut down the libraries?

Hon. Mr. Baetz: Whether you talk about ROM or the libraries or the symphony orchestras or the ballets or whatever, there has been, for several decades at least, very substantial growth which has been consistent with our economic growth and expansion. With economic growth having levelled off—or certainly not escalating the way it has been—I think the general public is going to be increasingly confronted with the question of how do you finance these public services and to what extent do you want them.

Ms. Gigantes: As long as they vote for you, obviously they will be confronted with that.

Hon. Mr. Baetz: They will be confronted no matter who they vote for.

Ms. Gigantes: No, I'm sorry. A drop from 16 per cent per annum increase in provincial funding to 1.8 per cent in provincial funding could only come from a Conservative government that hasn't figured out yet how to make library services the kind of political instrument it obviously has managed to make out of multicultural services. But you may be making a mistake. That's 1,500,000 people, Mr. Minister, who are served by that one library.

And do you know what's happening in the Ottawa area? The film service at the Ottawa library is being cut out totally because of lack of funding. We're going to lose one program after another in our libraries and when they come to you in Ottawa, I wonder what you're going to tell them. I know what I'm going to tell them.

Hon. Mr. Baetz: Yes, I'm sure you will.

Mr. Grande: It doesn't look as if the minister is going to say much to them.

Hon. Mr. Baetz: Just to go back to the basic question here the members of the general public are going to have to make up their minds whether they—

Mr. McClellan: Maybe they'll apply a means test at the library. Think you'll do that, Reuben?

Hon. Mr. Baetz: Maybe they so badly want all these services at a very high level they will vote you into power and then you can give it to them.

Ms. Gigantes: Do you believe in libraries as a community facility?

Hon. Mr. Baetz: Certainly, I believe in libraries—obviously I do.

Ms. Gigantes: Do you believe that only people who have enough money to pay for that should get it?

Hon. Mr. Baetz: I think today you have to be prepared to take a look at how you deliver that service. There may be less expensive ways of doing it than there have been in the past. There are all kinds of streamlined methods to provide a service, if the staff is prepared to adjust. I think these are the things you have to look at. I don't know.

Mr. McClellan: Tell us a little bit more about user fees. What do you have in mind? Have you got some suggestions for the library boards across the province about instituting user fees? What's a good user fee as far as you're concerned?

Hon. Mr. Baetz: I wouldn't be prepared to get into any detail on that subject at this point, no.

Mr. McClellan: You brought it up. I assume you must have something in mind as the minister responsible for funding.

Hon. Mr. Baetz: I'm raising it as one. One of the services that has been the centre of controversy is the use of films. It's an expensive service, a very nice service, but I guess you get back to the question, does the general public feel it can afford it? Are you prepared to increase taxes in order that you can provide a film service out of libraries?

Eventually it always gets back to this: increase taxes and you can do all kinds of things. But I haven't heard—

**Ms. Gigantes:** You can explain perhaps why between 1976-77, when provincial grants increased again on an average of 16 per cent, I presume—certainly over the decade—in 1977 they suddenly dropped. I didn't realize we had gone that badly down in 1977. I knew we were in trouble with you guys back in power, but I didn't know it was that kind of disaster.

**Hon. Mr. Baetz:** Mr. Roedde had some statistics a few days ago, I think. Are you ready to present them at this point, Mr. Roedde?

**Mr. McClellan:** Didn't do too badly with the statistics last time. You could take another crack at it.

**Mr. Roedde:** The statistics that I have, based on our Statistics Canada report, only go up to 1977. As I mentioned earlier, they show the rate of provincial support was ahead of the municipal support during that period of time.

In the last couple of years, 1978 and 1979, we will see municipal support and private support through user fees increase. Naturally we don't have statistics for those two years. But we know from our involvement with the library community, and especially through the planning process which involves the regional library systems in preparing their priorities, there are these decisions being made—to streamline services; increase efficiency; reduce services in some cases, such as the hours open; to increase revenue, such as user fees for films; and to clarify the responsibilities of the local libraries vis-à-vis the regional libraries.

For instance, I know the question of film service in Ottawa will be discussed by the board of the Eastern Ontario Regional Library System, as they determine what role the regional library system can play in films. Films are a natural regional service because of the cost of 16-millimetre films.

All this is going on and it is a part of a difficult process of budgeting, of establishing priorities. I think all we can do in the ministry, given the facts of financial constraints—

**Ms. Gigantes:** You mean the withdrawal of government support.

**Mr. Roedde:** —is, in the first instance, to assist in the establishment of priorities and the increase in the efficiency of the system. If additional funds are available at the provincial or local tax level, then that perhaps reduces the problem. But given the reality I face, I must work with the library commun-

ity, and I know they are all willing to do everything they can to increase their efficiency. This doesn't mean they don't make demands and that they are completely happy with the process. But it is all we in the ministry can do—that is, to endeavour to help the library community increase the efficiency of the whole operation.

**Ms. Gigantes:** Mr. Chairman, through you to the minister, can I ask Mr. Baetz, will he be supporting an increase in property taxes in the Ottawa area so that our library system will be maintained, at least? Obviously, that support is not going to be forthcoming from the provincial level of government. Will you be supporting an increase in property taxes at the Ottawa area level for that purpose?

**Hon. Mr. Baetz:** Mr. Chairman, I don't think that question is directly relevant to the estimates.

**Ms. Gigantes:** I believe it is.

**Hon. Mr. Baetz:** I don't think it is.

**Ms. Gigantes:** I believe it is, because you are telling us that's the alternative, in effect.

**Hon. Mr. Baetz:** Could I also, Mr. Chairman, make two other observations here? Relating to the Wintario non-capital grants, you keep saying that shows there is a decrease there from 1978-79 of \$2,252,000 to \$2 million. In other words, a decrease of \$252,000. Actually, that is a little deceptive, in that the amount actually used in 1978-79 in that line was \$1,770,000. So if they use everything this fiscal year that we have allocated, it could result in an increase over what they actually used last year.

**Ms. Gigantes:** I'm sure they'll be delighted to learn it is their fault they haven't had the \$252,000.

**Hon. Mr. Baetz:** They are certainly aware it's there. They can use it.

**Ms. Gigantes:** They can try to get it.

**Hon. Mr. Baetz:** If there was all that pressing need for it, one could assume that line would have been fully used up.

**Ms. Gigantes:** Let's hear your explanation of why they haven't been able to get it.

**Hon. Mr. Baetz:** There might be hundreds of reasons for it.

**Ms. Gigantes:** Could the minister give us his explanation? I'm sure I would like to take that back to the people who work in libraries and let them know why you're saying they haven't spent the funding that was available to them.

**Hon. Mr. Baetz:** I do not know why they did not. Maybe Mr. Roedde knows. I am simply reporting to you that if they—



**Ms. Gigantes:** I've heard this before.

**Hon. Mr. Baetz:**—spend \$2 million in the current fiscal year, they will be spending more than they spent last year. So it is not a decrease as you have indicated.

**Ms. Gigantes:** It must be very difficult for them to get their hands on those funds, because they are starved for funds.

**Hon. Mr. Baetz:** The other rather general observation here is how much is enough?

**Ms. Gigantes:** Well, 1.65 per cent is not enough.

**Hon. Mr. Baetz:** But when you say how much is enough, there are many ways of looking at it. I think one valid measuring stick is to take a look at how Ontario libraries are faring compared to libraries in other provincial jurisdictions. I have heard on many occasions my counterparts in other provinces say, "I wish we had what Ontario has." That includes Quebec along with the others. To leave the impression here that Ontario is starving its library system I think is incorrect.

I don't know if Mr. Roedde has the detailed statistics on comparative spending by provincial governments on libraries—

**Ms. Gigantes:** This means that it is your goal to reduce the service in Ontario to the level of other jurisdictions?

**Hon. Mr. Baetz:** Not at all. That is not our goal.

**Ms. Gigantes:** I want to know what your policy goal is.

**Hon. Mr. Baetz:** I'm simply holding this out by way of saying the libraries have not fallen on these evil days you are suggesting they have. When I say that, I am aware that there are difficulties.

**Ms. Gigantes:** I don't think they've fallen on them; I think they have been pushed to them.

**Mr. Roedde:** From the Ontario Statistical Review—1975 figures—the Atlantic provinces spent \$3.90 per capita of adult population on their public libraries; Quebec spent \$2.20; the central Canadian Prairie provinces, \$5.90; British Columbia, \$7.10; Canada as a whole, an average of \$6.30; and Ontario was highest at \$9.90. We're certainly one of the highest in terms of population served by public libraries at 90 per cent compared to—

**Ms. Gigantes:** That was before the cutbacks. That was in 1975.

**Hon. Mr. Baetz:** Those are the latest available statistics. We can't give you statistics that aren't published.

**Mr. Grande:** Don't use those statistics after the cutbacks in the last couple of years.

**Hon. Mr. Baetz:** There haven't been any cutbacks.

**Ms. Gigantes:** Oh, yes, there has been a cutback in funding in terms of dealing with inflation for institutions. You know what has happened to the price of books. The price of books has gone up more than the Minister of Education will tell you. She doesn't want to know any more than you do.

**Hon. Mr. Baetz:** We just hold this out as one way of measuring the level of financial support by this government to local libraries. It is not the only one, but I would hope you would recognize it does tell a story.

**Ms. Gigantes:** It tells a story which is over; it doesn't tell the story of what is happening now. It is precisely what is happening now that I wish to find out about. I wish to know what your policy goal is.

**Hon. Mr. Baetz:** Our policy goal is certainly not as you have suggested to gradually strangle our local libraries. That is not the policy at all.

**Mr. Grande:** You just phase out the regular support to the libraries.

**Hon. Mr. Baetz:** Oh, by no means.

**Ms. Gigantes:** Thank you, Mr. Chairman. I'll look forward to meeting you in Ottawa on this one, Reuben.

[5:30]

**Mr. di Santo:** I would like to ask a few questions about an issue which is more parochial, but it is one of my concerns and the concern of some people in the Italian community. I would like to ask the minister how he feels about an application of the ICBC, the Italian Canadian Benevolent Corporation, for a capital grant in the amount of \$3.6 million for the construction of a so-called cultural centre, the Columbus Cultural Centre, at Lawrence and Dufferin?

The question stems from the fact that even though there is a consensus among the members of the Italian community for the construction of such a centre, which can certainly serve a useful purpose; and even though I think there is a need for a centre where cultural and recreational activities can be developed and a place where those members of the Italian community who choose can go and use them for cultural and recreational purposes, there are, though, some concerns about the way the whole project has been brought out.

As you know, the ICBC is a non-profit organization with the purpose of raising funds in the Italian community to devote to various organizations and groups in the social and charitable areas. The point is this:



the members of the Italian Canadian Benevolent Corporation are running the corporation as a business which has no public scrutiny. The membership is extremely restricted and there is virtually no control over the way they operate. In fact, there has been a lot of criticism for that reason.

Also, the new project seems to be directed to satisfy only a small group in the community. Just to give an example you have in your application, the squash club is restricted to 200 members for men and 150 for women. I don't understand why there is that difference. Anyway, they are talking now of a membership fee to the centre which will be substantial. It will be in the range of \$1,000 to \$2,000, a year, which will restrict the participation of the Italian community at large.

I would like to ask you: How do you feel about this project?

**Hon. Mr. Baetz:** The squash club or the overall?

**Mr. di Santo:** No, the whole thing.

**Hon. Mr. Baetz:** The overall project. Well, I have, as you may know, visited the Villa Colombo on several occasions. I have also had discussions with the executive of the ICBO.

**Mr. di Santo:** ICBC.

**Hon. Mr. Baetz:** Yes. It is no secret—in fact, I guess there was a big story in the Toronto Star last week—that there is a tremendous amount of tension between these two bodies. I frankly think that at this point in time our ministry should view the thing from a distance. Surely this is something that has to be sorted out between these two organizations. Before we get too deeply involved with one or the other or with both—

**Mr. Grande:** You are deeply involved; you know that.

**Hon. Mr. Baetz:** Yes, but we will have to look to them to sort out their problems, and they have problems. I am not sure what is behind the question. Surely the question doesn't imply that this ministry should act as sort of a policeman between the two, or as a clearing house or anything else.

**Mr. di Santo:** No, absolutely not. That is far from my mind. I don't know what the guidelines are in this case, but there is a substantial amount of money involved. I am personally in support of the project, but when you deal with a group don't you have to be sure that certain basic rules are respected, for example, that the organization be open to public scrutiny?

**Hon. Mr. Baetz:** Exactly.

**Mr. di Santo:** The fact is that last Friday one of the directors of ICBC was arrested for bribery. Another director was also very prominent in the Waisberg report on violence in the construction industry. Another director, who I think has resigned recently, is very prominent in the last book published by Morton Shulman on the same topic. Don't you think when dealing with these people that you should be more careful? Above all, at the moment when you are granting \$3.6 million should you not be sure if they are applying on behalf of a community, in this case the Italian community, that they reflect some of the Italian community and that they are not a small group of people, who are bringing forward a project that maybe does not reflect the general concern of the community?

**Hon. Mr. Baetz:** You are certainly making some very valid observations. Maybe I should return the question and say do you think that the Italian community will sort this out among themselves very quickly?

**Mr. Grande:** You are here to answer questions, not to ask them.

**Mr. di Santo:** Perhaps I should preface my remarks by saying that these people do not belong to my party. The people who run the congress are Liberals and the people who run this organization are mostly Tories.

**Hon. Mr. Baetz:** We are the bad guys and they are the good guys?

**Mr. di Santo:** I am not here to defend the Liberals against the Tories. What I am saying—and this is very serious and not facetious—is that it is a large project. They are speaking on behalf of the Italian community, but there is not a single worker on this board of directors, though 99 per cent of the Italian community is made up of workers. If they impose a membership fee of \$2,000, can you tell me how many people can afford that? The congress is an organization. It is labour but it is an organization which represents most of the Italian organizations, clubs and associations throughout Canada, so they should have some say.

I would like to have your feelings. What do you think about that? I am not as nasty as my friends, as you seem to say.

**Hon. Mr. Baetz:** I would only like to say here in this public way that we are very much aware of the problems, the difficulties and some of the tensions that exist and certainly we will not go into this or continue to proceed with a blind eye.

I was not aware of some of the revelations you made today about certain individuals and I shall take that under advise-

ment. I am not being facetious. It is a problem and one that is of concern to us, and it is one we are closely monitoring so we will not end up having made very quick decisions we will have to feel sorry for down the line.

**Mr. di Santo:** Is it fair to say that given the fact the guidelines are respected you are willing to finance the project but will ask for some guarantees?

**Hon. Mr. Baetz:** Of course, we ask for guarantees in every project.

**Mr. Grande:** Until you decide to break them.

**Hon. Mr. Baetz:** No, we don't break them.

**Mr. Grande:** I have just one question on that. Is the minister aware the ICBC received over \$3 million in order to buy that site from the Ministry of Government Services?

**Hon. Mr. Baetz:** Yes.

**Mr. Grande:** The minister is aware, so don't wash your hands and say we're going to be careful in the future. You've already done it.

**Hon. Mr. Baetz:** You also know there are plans for great expansion.

**Mr. McClellan:** Expansion of what?

**Hon. Mr. Baetz:** If that comes to my attention or applications are made to my ministry, we're aware of the difficulties that exist and we're not going to be breaking any of our criteria. We'll be applying them.

**Mr. Grande:** Public accessibility is guaranteed provided you pay membership of over \$2,000.

**Hon. Mr. Baetz:** If that is going to be their standard of public accessibility, then I don't think Wintario would be in a position to support it.

**Mr. McClellan:** They can always go to Government Services.

**Mr. Grande:** Mr. Chairman, I did say I have some questions regarding financial services.

**Mr. Chairman:** Yes, that's item 2, Mr. Grande. Shall item 1 carry?

Item 1 agreed to.

On item 2, financial services:

**Mr. Grande:** On financial services, I have two very quick questions. When are you planning to lift the freeze on Wintario capital construction? I have heard statements ranging from two to three months to one of about two years. When are you going to lift that freeze?

**Hon. Mr. Baetz:** To say it will be in two or three months is overly optimistic. To say it will be in two years is overly pessimistic.

**Mr. Grande:** Say when then.

**Hon. Mr. Baetz:** We deliberately did not announce a deadline for the completion of the study and the presentation of recommendations, but in my own mind I'm still thinking in terms of late this year. I think the main point to keep in mind, even if it takes two or three months longer than anybody had wished or had planned it to take, is that we do a thorough study. We must canvass all of the views that should be canvassed and not simply to meet this sort of self-imposed deadline, draw our conclusions and say here's what shall be in the capital program for the next two or three years onwards and perhaps come up with the wrong proposals.

**Mr. Grande:** At the end of that experiment will your proposal be to change the Wintario guidelines for capital projects? Is that what it is?

**Hon. Mr. Baetz:** I wouldn't say here today they will be changed. They may be, but it will depend on what we discover, the feelings and the needs and the resources at the local level, communities, individuals, and voluntary agencies. We intend to canvass their views thoroughly and, as you know, we've been encouraging a local needs and resources study in the culture and recreation field. We've been helping to finance some of those. We think that will be most useful. [5:45]

As I said, rather than to try to meet a self-imposed arbitrary deadline and come up with a half-baked job, my feeling is that we would be prepared to go a few months further and come up with a well-thought-out and a well-researched document and recommendations.

**Mr. Grande:** In the meantime, since Wintario creates approximately between \$5 million and \$7 million a month in profits, and since the freeze, as I pointed out in my leadoff remarks, was in effect since August 1 of last year and you are saying it will continue until the late part of the year, meaning past August of this year, what are you doing with the \$60 million to \$70 million in profits?

**Hon. Mr. Baetz:** In that question you have to keep in mind—and I don't think you did—that when the freeze went into effect at the end of December—that's when it went in, not the end of August—

**Mr. Grande:** I will point out to you—

**Hon. Mr. Baetz:** I know you indicated earlier that you don't agree with that date, but when the freeze went into effect one must



keep in mind that Wintario had commitments for capital programs of \$48 million and those payments are going out daily. It isn't a case of suddenly at the end of December no more payments to anything. We're continuing to meet our earlier financial commitments. Even though you have an August date in mind it was December 31.

**Mr. Grande:** August 1, to be exact.

**Hon. Mr. Baetz:** Any applications that came in before the deadline have been processed, and those that have met the criteria have been approved and will get their financing. So the gap or the lull in financing is not what you might fear it to be.

**Mr. Grande:** Just to show you that the freeze came into effect August 1, you sent out to organizations a letter with a date of August 1 saying: "Effective August 1, 1978, and until further notice, Wintario capital grant applications for confirmation and eligibility and approval, since there has been no previous confirmation of eligibility issued, will be assigned an A and B priority according to the following."

In other words, you set out your particular inventory at that particular time, and that's the time you said "a capital cost sharing agreement with the municipality which provides for municipal commitment of at least five per cent of the total capital cost," and then two months later you retreated very hastily on that subject. However, it does say that as of August 1 Wintario capital grant applications were indeed frozen.

On November 2, prior to your announcement in the Legislature, people in Wintario were called, because we got some people calling our office, and my notes say: "The person from the Wintario office says a ministerial announcement is expected within the next week or so outlining the changes to be made. What has happened is that the capital grants application has become so popular that they have received so many applications for this type of funding that they must now restrict what they fund more closely than before. All capital grant applications are being held up at the moment while the ministry reassesses its priorities."

That is what people got over the phone prior to you making the announcement in the Legislature about the freeze. Not only that, but people were told over the phone: "Don't send in your application. Hold off, because there are going to be changes in the criteria." So in a sense what you have done is restricted people who might have sent in their Wintario application to be considered and therefore be eligible for funding

from the date you made the statement in the Legislature; you held these people at bay saying: "Don't put in your application. It won't be considered."

**Hon. Mr. Baetz:** Mr. Chairman, I just want to make one comment, then with your permission I'll ask Mr. Tieman to comment further. I would only say that anybody who had started to process an application prior to December 31 got in under the wire. In fact, if there was any question about whether one got in under the wire or not, we always listened rather than taking a hard-line approach.

It is true that in August, unfortunately, in one or two of the regions some memos did go forward indicating that there was some kind of a temporary freeze or whatever, but, as you know, I clarified that issue in the House and indicated that the new criteria would not be applied, particularly the criteria which required that there should be municipal funding of up to five per cent of any voluntary agency project. As you pointed out in the House, and as I confirmed, we regarded that as giving a municipality veto power over any project in the community. We felt that that was going too far.

**Mr. Grande:** You certainly didn't do it.

**Hon. Mr. Baetz:** Anyway, all of that was withdrawn. If you can show me any project that, because of what transpired in August, somebody told the applicant or wrote to him: "The criteria have changed. Don't submit your application," if you have anything like that pass it on to me and we will take a look at it.

**Mr. Grande:** I will take that seriously.

**Hon. Mr. Baetz:** I think the cutoff at the end of the year went extremely well. I certainly know of no case where people are charging that they had been done or that they had been unfairly dealt with. Not one case has been brought to my attention, which is rather remarkable when you think that there were many hundreds of cases in the mill at the time. I think Mr. Tieman could shed a little more specific light on this business of what happened in August, which was just about the time I came into the ministry.

**Mr. Tieman:** Mr. Chairman, I am not sure I can add very much more to what the minister has brought to the attention of the committee. I don't have a copy of the minister's statement with me, the one he made to the House in November, but I remember quite clearly his concern about those applications that had been put in abeyance for the previous month or two be-



cause of some discussion and some lack of determination about either the new criteria or whether there would be a moratorium, and a number of other considerations that were being discussed at that time. I'm quite certain his statement indicated that anybody who had been held up would be free to apply up until December 31.

I recall his concern about providing for those situations, rather than announcing an immediate moratorium, providing six or seven weeks for everyone who may have been in the situation Mr. Grande mentioned. We were well aware that a number of people had been told to hold on until we were sure about the program and the criteria. I'm not aware of anybody who did not get an application in after the minister's statement and before the moratorium came into place on January 1.

Mr. Grande: I'm saying to you that I'm aware of some people and I will encourage them to put in their applications. I asked you the question of what you were going to do about the Wintario money that is going to be accumulating. So it's not going to be \$60 million to \$70 million because of prior commitments that the ministry has, but it's going to be around \$40 million or \$50 million. Are you saying that the ministry's commitments were such that they were one year behind in terms of money coming in from Wintario? Is that what you're saying to me?

Mr. Tieman: No.

Mr. Grande: There must be some money left over. Since, clearly, 75 per cent of the money for Wintario applications is given out in capital grants, you must have a good chunk of that money left over somewhere.

Hon. Mr. Baetz: There's certainly a time lag between processing and giving authorization or confirmation of eligibility and the actual day when the first instalment is made. The time lag is very considerable; in some cases, eight or nine months. It isn't a matter of the application coming in one day and four days later the cheque goes out, because it often takes voluntary agencies or others time to get their fund-raising together and organize their programs and so on.

Mr. Grande: Going back to the question I asked on the order paper a little while ago: Will you continue with that format for the amount of money that is coming in from Wintario; the amount of money that is committed; and the amount of money that is actually sent out for each of the months beginning—you started that up in November

1978—so then we'd really find out how much Wintario money there is?

Hon. Mr. Baetz: That's right.

Ms. Gigantes: You can't really tell until you know how much the libraries are going to be able to spend.

Mr. Grande: The other question I have, Mr. Chairman, regards Loto Canada money which has been coming into the ministry since 1976. The ministry, right now, has in its possession, or the general revenue fund contains, approximately \$5.6 million of Loto Canada money. Since 1976, your answer to me has been that you hadn't decided how to spend the money. When you are going to decide how that money is to be spent; how that money is to be allocated. Why did it take from 1976 to 1979—three years—before anyone even knew about its existence? It was not included in any set of estimates I'm aware of. I asked the question first in the House, then you hastily put together the supplementary estimates for 1979-80 to indicate that \$5.6 million from Loto Canada was included. How are you going to use that? When are you going to make the decision as to how those funds are going to be utilized?

Hon. Mr. Baetz: As we indicated in the report we tabled, the final arrangements in regard to the use of these funds have not yet been concluded. That is correct. We have been negotiating with Metropolitan Toronto, for example, on the possible use of those funds, but no final agreement has been reached.

Mr. Grande: Why are you discussing with Metropolitan Toronto the money that comes in from Loto Canada? I understand that 50 cents of every ticket sold in Ontario comes into the ministry, you decide how to use it. You decided that the Lottario money is going to be used for the same purpose as the Wintario money is used. That's clear. But you never made a statement regarding how the Loto Canada money is going to be used. Why are you holding back? Why have you been holding back?

Hon. Mr. Baetz: Loto Canada funds, as you know, will be terminating at the end of this calendar year. Loto Canada is not to be confused with Wintario or Lottario or the Provincial lottery. It's quite different.

Mr. Grande: I'm not confusing it.

[6:00]

Hon. Mr. Baetz: One of the possible projects that was actively considered was some assistance to the CNE for their stadium. The rationale for that was very

straightforward. Loto Canada, and before it the Olympic lottery, as you will recall, was directed largely to the Montreal stadium, the Olympic stadium. Hundreds of millions of dollars went to that. It was quite logically questioned or considered whether perhaps some kind of assistance might be given to a similar program here in Toronto, but no agreement has been concluded.

There has been talk back and forth. I don't think there's any great secret about that. As early as 1974, there were press reports about the possible funding of the CNE stadium, more on a refundable grant basis than as an outright gift. There has been nothing secretive about it.

**Mr. Grande:** Is the interest on the money in the general revenue fund being used as cash flow for the government of Ontario?

**Hon. Mr. Baetz:** It's there for our use. When we reach an agreement with whom-ever, the funds are there and will flow out.

**Mr. Grande:** The interest will?

**Hon. Mr. Baetz:** Presumably the interest is there, yes. That's a question you should really direct to the Treasurer rather than to me. You've had his assurance in the House that any revenues which have flowed into consolidated revenue from lotteries will, when and as required, also flow out.

**Mr. Grande:** It's a question directed to you because you've been quoted in the *Globe and Mail*, I believe, as saying that no one is concerned about the interest the Wintario money is accumulating. You said nobody seems to be concerned about that. Why are you concerned then?

As a matter of fact, you were referring to one of the speeches you made to the arts community. The arts community had brought forward to you a very reasonable proposal of a Wintario trust fund. They were suggesting to you that purely out of the interest money that comes from Wintario and other lottery sources you could provide money to all the arts community, all the arts groups and everyone else in the province, without even touching the capital. Are you considering a Wintario trust fund?

**Hon. Mr. Baetz:** This particular group has made this proposal on a number of occasions. What they're really saying is they want to set up an endowment fund. Then a small board of directors, chosen by, I don't know by who and I don't know under what terms of tenure or anything else—

**Mr. Grande:** I'm sure it can be worked out.

**Hon. Mr. Baetz:** —would decide how best to use the income generated by the endow-

ment fund for the arts field. We have looked at that as a possibility and have so far been persuaded that that's not the best way to dispense lottery funds.

**Mr. Grande:** Because that will be taken off your hands. Is that why?

**Hon. Mr. Baetz:** Not really. We have an Ontario Arts Council today that is attempting through its program to set priorities. Then here you would set up a counterpart organization that does the same thing. That was one of the considerations.

**Mr. Grande:** The Ontario Arts Council does not disburse Wintario money though.

**Hon. Mr. Baetz:** Of course it doesn't, but it might be financing many of the same people this arts group would be financing as well. If you take up, as possible candidates for receiving funds from this arts group that wants to manage this fund—if you say remove all individuals or organizations that get money from the Ontario Arts Council, you have not got a heck of a lot of people left. It raises the question about the whole sports field, the whole recreational field, grants to municipal endeavours and so on. So far, it has not been seen as a very good *modus operandi*.

**Mr. Grande:** For very good political reasons, I would venture.

**Hon. Mr. Baetz:** I do not think it is for good political reasons. We heard the member from the Liberal Party point out the other day right in this meeting—and I think you heard him—the tremendous value of Wintario in how it has been financed up until now, what it does for communities and how it brings communities together around a community centre, getting people involved in fund-raising and matching money.

I think the Wintario story is a success story so far. If it were not so, obviously we would be taking a much harder look at this kind of proposal, that we should set up an endowment fund. The committee members will have a chance to convey their views about how future financing ought to be made in Wintario because every MPP will be interviewed. If you feel that is the best way to do it, that will be a good time to state your case. I know you can do it right here too, and you probably are doing so, but I am not yet convinced that is the best way to do it.

**Mr. Grande:** It would take it off your hands so that it lessens the temptations.

**Hon. Mr. Baetz:** If you can pinpoint flagrant cases—

**Mr. Grande:** I have done it.



**Hon. Mr. Baetz:** —of having politicized Wintario, I would like to hear about it, because the tradition has been—and it's one I have tried to follow—to make it a strictly nonpartisan and nonpolitical operation. I tell you that and I suspect every member of every party would tell you the same thing. I have never yet tried to make a breakdown as between who sponsored what and how many projects got approved, but I can assure you that if you were to canvass members of all parties they would say they have done pretty well, thank you. Projects of theirs which have been worthwhile and which have met the criteria have been financed.

**Mr. Grande:** All I am suggesting to you is that this is a golden opportunity, since you have instituted the freeze and since the money from Wintario is rolling in but you are not going to give out the money in terms of applications because of that freeze, to set up a new direction for Wintario to lessen the temptations that are there.

I pointed out during the last set of estimates how Mr. Welch went up to Timmins and with the mayor and other people presented a cheque to the La Ronde cultural club. I am not pointing particularly to the La Ronde. I think it is a good facility. What I am saying is it certainly does not leave a tremendous taste in anybody's mouth when you say that Wintario and the money given out from Wintario are apolitical. I do not believe that any funds that are given out are apolitical. When we talk about politics, we talk about priorities of funds. That is what we are talking about, there is nothing else.

**Hon. Mr. Baetz:** I could cite another example. You say Mr. Welch went to Timmins. I can say that last Christmas the Speaker (Mr. Stokes), who happens to be a member of your party, went home—

**Mr. Grande:** He is neutral.

**Hon. Mr. Baetz:** Before he became Speaker—and had a very magnificent cheque to give for a very worthy cause.

Item 2 agreed to.

Vote 3001 agreed to.

Votes 3004 and 30055 agreed to.

On vote 3006, sports and fitness program:

**Mr. Chairman:** I would like to know what Doug McCullough and Bob Secord are doing in this one. Are people in Ontario in better physical condition than they were a year ago, Mr. Secord? If not, why not?

**Mr. Secord:** I certainly am, Mr. Chairman.

**Mr. Chairman:** That's good; that's encouraging.

**Mr. Secord:** It's that wide-angle lens we talked about.

**Mr. Grande:** What happened to all those vans that were supposed to criss-cross the province and test everybody on sight? Are they all in operation now or is there still only one?

**Mr. McCullough:** They are criss-crossing the province and testing everyone on sight.

**Mr. Grande:** Are they? Okay.

Vote 3006 agreed to.

Vote 3007 agreed to.

**Mr. Chairman:** This completes the estimates of the Ministry of Culture and Recreation.

I have a brief constituency problem. Would the committee spare me 30 seconds? I haven't been able to spend much time in my office this afternoon. I had a constituent who applied to the Ontario Heritage Foundation for a research grant to compile information towards publication of a history of Kincardine and Kincardine township, and the application was turned down.

Some hon. members: Oh, no!

**Mr. Chairman:** Yes, it was turned down. My question is, where do I turn now?

**Dr. Wright:** I'll pursue that for you, Mr. Chairman.

**Mr. Chairman:** All right.

The next meeting, I should tell the committee, is on Monday, April 23, at which time we will be pursuing the matter of the Lakeshore closure and the annual report of the Ministry of Health. We will not sit tomorrow.

The committee adjourned at 6:12 p.m.



## CONTENTS

---

Tuesday, April 17, 1979

Ministry administration program .....	S-95
Main office .....	S-95
Financial services .....	S-114
Sports and fitness program .....	S-118
Adjournment .....	S-118

## SPEAKERS IN THIS ISSUE

---

Baetz, Hon. R. C.; Minister of Culture and Recreation (Ottawa West PC)  
 Blundy, P. (Sarnia L)  
 di Santo, O. (Downsview NDP)  
 Gaunt, M.; Chairman (Huron-Bruce L)  
 Gigantes, E. (Carleton East NDP)  
 Grande, A. (Oakwood NDP)  
 McClellan, R. (Bellwoods NDP)  
 O'Neil, H. (Quinte L)

**From the Ministry of Culture and Recreation:**

Diakowsky, M., Acting Director, Multicultural Development Branch  
 Eastham, K., Director, Newcomer Services Branch  
 McCullough, J. D., Assistant Deputy Minister, Sports and Fitness Division  
 McPhee, R., Executive Director, Citizenship Division  
 Roedde, W., Director, Provincial Library Services Branch  
 Secord, R. E., Executive Co-ordinator, Field Services  
 Tieman, W. D., Executive Director, Finance and Administration Division  
 Wright, Dr. D. T., Deputy Minister





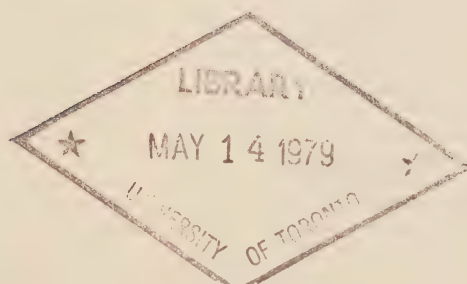
No. S-5

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Monday, April 23, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

### STANDING SOCIAL DEVELOPMENT COMMITTEE

**Chairman:** Gaunt, M. (Huron-Bruce L)  
**Vice-Chairman:** Kerrio, V. (Niagara Falls L)  
Belanger, J. A. (Prescott and Russell PC)  
Blundy, P. (Sarnia L)  
Cooke, D. (Windsor-Riverside NDP)  
Gigantes, E. (Carleton East NDP)  
Grande, A. (Oakwood NDP)  
Jones, T. (Mississauga North PC)  
Kennedy, R. D. (Mississauga South PC)  
Leluk, N. G. (York West PC)  
McClellan, R. (Bellwoods NDP)  
O'Neil, H. (Quinte L)  
Pope, A. (Cochrane South PC)  
Ramsay, R. H. (Sault Ste. Marie PC)  
Rowe, R. D. (Northumberland PC)  
Sweeney, J. (Kitchener-Wilmot L)

Hansard subscription price is \$15.00 per session, from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, 9th Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3. Phone 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

## LEGISLATURE OF ONTARIO

---

MONDAY, APRIL 23, 1979

The committee met at 3.50 p.m.

### MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

**Mr. Chairman:** I see a quorum. I should mention to the committee that we do have some substitutions today: Mr. Gregory for Mr. Belanger, Mr. Conway for Mr. Kerrio, Mr. Lawlor for Ms. Gigantes, Mr. R. F. Johnston for Mr. Grande and Dr. Duksza for Mr. Cooke.

Today we are here to consider the annual report of the Ministry of Health, and in particular the closing of the Lakeshore Psychiatric Hospital. I think the steering committee has been alerted to a tentative agenda for tomorrow and Wednesday, and then the days next week, Monday, Tuesday and Wednesday. Perhaps we could start off with the minister's statement then.

**Hon. Mr. Timbrell:** Thank you, Mr. Chairman.

**Mr. McClellan:** Do you have copies of the agenda?

**Hon. Mr. Timbrell:** I am not sure, do I?

**Mr. Chairman:** Do you have the agenda? Yes, Mr. McClellan, we have.

**Hon. Mr. Timbrell:** Mr. Chairman, I am pleased to meet with the committee today and to share with you some of the steps we are taking to maintain the high level of health care in the province.

While there may be disagreement among us on some points, I know there is no dispute that Ontario does have one of the best health-care systems in the world, and we are all of us committed to maintaining this standard.

The initial focus for the discussion here relates to the provision of mental health services in the area usually referred to as the golden horseshoe, the area between Hamilton and Oshawa. I'd like, if I may, just to set the background.

In the area concerned, four of our institutions provide a mixture of outpatient and residential services. East to west they are the Whitby Psychiatric Hospital, Queen Street Mental Health Centre, Lakeshore and Hamilton psychiatric hospitals. Combined, these hospitals currently provide services to 3,700

outpatients and can accommodate 1,900 resident patients. Last year we spent \$61.8 million to operate these four hospitals.

While I will go into more detail later, I think it is useful to note that the split between outpatient and inpatient population has shifted significantly in the last decade. There has been a dramatic reduction in the inpatient population, despite a rapid growth in the population as a whole. Over the last 10 years the inpatient population at our Ontario psychiatric hospitals has declined from about 7,800 to about 4,000; in fact if you go back to 1963, the reduction is even more dramatic, from approximately 16,000 at that time to about 4,000 now.

The shift is consistent with the belief that many psychiatric patients can often be treated and accommodated outside of the traditional psychiatric hospital setting. A direct effect of the shift, and this is an issue we are concerned with today, is that we have 1,900 beds in the four institutions and we have only 1,365 patients requiring continuing institutional care. As we feel the shift from residential to outpatient care will continue, it makes no sense, economically or socially, to maintain such a large number of empty beds.

Some of the facilities are outmoded; more than that, some are unsuitable and even unsafe. Some of the buildings are in immediate need of renovation, at very considerable costs during a period when funds are limited.

The solution, obviously, is to move patients into the best accommodations available, and to either eliminate or convert the vacant space to other uses. In short, this is what is happening at Lakeshore hospital, where we already have begun the transfer of a number of inpatients to the Queen Street Mental Health Centre where there is a surplus of beds. The Queen Street Mental Health Centre, which has been totally rebuilt at a cost of \$41 million, is one of the most modern mental health facilities in the world. At the same time we are proceeding with a master plan for the reconstruction of the facilities at Whitby and the increased utilization of vacant space at Hamilton.

As many members know, sections of the Lakeshore facility were built 89 years ago;

in fact I think there is one building that is even older than that. The oldest part of the Queen Street complex, by contrast, was built just over 20 years ago and has recently been renovated. Anyone visiting the two hospitals will draw the obvious comparisons.

Now for the benefit of the committee, Mr. Chairman, it might be useful to see a few illustrations of the differences between the two hospitals. If we could have the lights out we will show you a few slides.

**Mr. McClellan:** Is it set to music?

**Hon. Mr. Timbrell:** No, it hasn't been choreographed either.

First, Mr. Chairman, we have a view of the exterior of the Queen Street Mental Health Centre. This is the facility which was recently officially opened; which contrasts, I think, sharply with that of the Lakeshore Psychiatric Hospital.

**Mr. Lawlor:** Grand old rococo style.

**Hon. Mr. Timbrell:** Mr. Chairman, next we have an illustration of the bright, glassed-in walkways which connect the buildings at the Queen Street Mental Health Centre; I would ask you to compare that with the situation at Lakeshore, where patients and staff must use dimly lit, underground tunnels to reach other parts of the hospital in inclement weather.

**Mr. Conway:** It's like the Legislature.

**Hon. Mr. Timbrell:** It's about the same vintage.

The modern, cheerful dining rooms at Queen Street have recreation areas nearby; whereas this is a typical Lakeshore Psychiatric Hospital dining area. The Queen Street facilities contain the most efficient equipment to move food; these are Amscar motorized units that move on tracks by remote control to bring food to the patients. This contrasts with the food carts at Lakeshore that have to be pushed around manually from building to building.

This is a spacious, semi-private room at Queen Street in the psychogeriatric unit. What we don't show here are the whirlpool baths and modern bathing facilities, which make the bathing of these elderly patients comfortable and therapeutic.

All of the psychogeriatric patients at Lakeshore, before their transfer to Queen Street, were housed in wards such as these. There was no real privacy, although staff have done their best by putting up screens and curtains. Bathing facilities were antiquated, and at best were awkward to use.

[4:00]

The comfort for patients in modern surroundings is apparent in this view of a private room at Queen Street. Most of the accommodation is private or semi-private, and all areas are air-conditioned. There are no private rooms at Lakeshore and no air-conditioning.

Queen Street Mental Health Centre has an abundance of bright, attractive lounge areas and meeting places throughout the facility; which is a dramatic contrast with limited lounge areas at Lakeshore that remain somewhat bare despite efforts to brighten them with curtains and chairs.

Entertainment is scheduled regularly in this comfortable 300-seat auditorium at Queen Street; whereas this is the Lakeshore auditorium, which also doubles as a gymnasium and is the only indoor recreation area. I would ask you to contrast this with the modern gym at Queen Street and a large skylit mall where patients and friends congregate.

Staff members and community groups share the Queen Street recreation facilities—which I may say is, I think, one of the more important design aspects of Queen Street, that there is a constant interchange with the community.

Additional facilities not found at Lakeshore are a swimming pool and a library, which in addition to regular reading materials offers newspapers in many languages, magazines, music tape recordings for all ages and special large print publications for patients who have vision problems.

Mr. Chairman, I could continue at length, with more slides and additional statistics, but I'm not going to belabour the point that the conditions for inpatients are significantly improved by the move.

The quality of physical surroundings for our patients has improved substantially, but this is only half the improvement. With the number of Lakeshore staff members who are also moving to Queen Street, we are ensuring the best possible standard and quality of care for patients. Certainly the continuity of care provided by the same staff will be beneficial.

The ratio of staff to patients in psychiatric hospitals, as a matter of fact has improved dramatically since the beginning of this decade. The Queen Street centre, as an example, increased its staff-to-patient ratio from 1.25 in 1970 to 2.71 in 1978. The same is true elsewhere; in fact the average ratio for all of our psychiatric hospitals has increased from 1.18 in 1970 to 2.10 in 1978.

These changes are having a beneficial effect on residential and out-patients at all our hospitals, including Lakeshore, and are having



a significant impact on the employees who contribute so much to the improvement in health care in these communities.

Unfortunately, some staff members at Lakeshore will be affected by the gradual shut-down. Part of the amalgamation of services with the Queen Street Mental Health Centre will absorb about 350 staff members by September. Some 230 layoff notices, effective August 31, were issued by the ministry to personnel at Lakeshore.

In efforts to relocate these employees, a personnel committee consisting of Ministry of Health management representatives and the Ontario Public Service Employees Union was established. The ministry imposed a hiring freeze in its institutions and offices where Lakeshore personnel might be employed to ensure these persons would have first opportunity at jobs as they become available.

Opportunities are also available in public service jobs for employees willing to relocate outside Metro, and relocation assistance is offered to such individuals.

As well, administrators of general hospitals in Metro have been contacted to examine possible employment opportunities, especially in those hospitals which have psychiatric units.

A number of staff members have been transferred within the ministry as a result of positions posted at Lakeshore; some have transferred to other ministries, while still others have relocated at local hospitals. Discussions are continuing to locate jobs for those remaining on the layoff list.

I am told the layoff list has been reduced to 170 due to in-government transfers, retirements and resignations of those who have obtained outside positions. That includes both members of the bargaining unit and management. The last time I met with OPSEU, their number was much lower, but as I recall that was strictly for members of the bargaining unit.

So far I have been talking principally about residential patients, but Lakeshore also provides a base for a substantial range of outpatient and day services. As I said earlier, it must be recognized that modern treatment methods place a greater emphasis on the care of patients in their own communities wherever possible, and on programs that serve the needs of the patient and community. More and more, there is a growing emphasis on community-based treatment.

This view is shared widely by mental health professionals, mental health associations, public health personnel and volunteer groups. Active participation by such sources was considered essential in the planning which has gone on to relocate services and

expand programs. These services will be expanded by funding made available as a result of direct cost savings from the Lakeshore closure.

The services will be spread more evenly through the communities concerned for the convenience of patients and their families; \$1.3 million will be allocated towards this end.

At this point, Mr. Chairman, I think it's important to stress that the phasing out is a gradual and orderly closing down of out-moded inpatient facilities, and a relocation and expansion of outpatient services in the area previously served by Lakeshore Psychiatric Hospital.

To continue, this decision to expand treatment into the community is not a unilateral decision on the part of the ministry. Rather it involves participation by a number of groups and representatives of the areas concerned.

To co-ordinate the recommendations originating from the areas concerned, an implementation committee was appointed earlier this year and charged with two main responsibilities. First the committee was to concern itself with the continued provision for service for outpatients; second, the committee was asked to develop suggestions on how best to expand and improve mental health services in the Lakeshore area. It is the recommendations of the committee and other groups that the ministry is now assessing and will use as the basis for decisions about new and expanded programs and services to be funded in the areas affected by the closure of Lakeshore.

The makeup of the implementation committee was broadly based, with representation from public health and mental health associations, volunteer groups and others, including officials of local hospitals with psychiatric facilities and the local health planning bodies, namely the Peel District Health Council and the Hospital Council of Metropolitan Toronto.

Given the time constraints, it is evident the ministry has not been able to review all the suggestions. In fact Friday last, April 20, was the cutoff date for submissions to be in to the ministry. However, I would like to touch on some of them for you.

For example, reference has been made to relocating outpatient and aftercare services formerly supplied by the Humber building into Peel, Etobicoke and North York, in order to bring these services into the home areas of the patients concerned. As I'm sure most of the members, or at least some of the members will know, the DARE program

that has functioned in Etobicoke, off of the Lakeshore grounds, continues to operate in its present location.

Consideration will be given as well to requests regarding the relocation of the alcoholism treatment centre. We must be sure that easy access to this treatment service is continued. A suggestion has been made that this program remain at the Lakeshore site, and we will certainly give that proposal serious consideration.

The ministry is also studying recommendations made in connection with the behaviour and speech therapy services. One suggestion from the Etobicoke community group looking at the question is that the latter be incorporated into the Lakeshore Area Multi-Service Project, known in the community as LAMP, and the former in a general hospital somewhere in Etobicoke.

The future location of the occupational and industrial therapy program is another consideration. The feasibility of retaining this service on the grounds of Lakeshore will be examined, as has been requested by the Etobicoke group.

I think it is appropriate at this time to advise the committee that the question of the future use of the land is being considered in consultation with the Ministry of Government Services, and the government has decided it will be retained for public use.

Various new services for the areas affected by the scheduled Lakeshore closure have been proposed as well. These include establishment of new mechanisms for co-ordination of mental health services in Etobicoke, North York, Toronto and Peel; as well as the establishment or expansion of: rehabilitation, counselling and medication monitoring programs; group homes and other residential accommodations; expanded outpatient day-care and crisis intervention services; special services for psychogeriatric patients; activity centres and services for patients in their homes who are unable to leave home for treatment, or for whom home treatment is an appropriate therapeutic method.

Obviously we have not had time to consider all of these suggestions but they do reflect constructive and creative thinking in the approach to the delivery of mental health services.

The most significant shift, as I have noted, has been away from institutionally based services in the psychiatric hospital to a community base in the public general hospital and to improved community services. Although the population is growing, treatment methodology is reducing time spent in hospital. The alternative forms of treatment,

through day care, outpatient services and community support services, for example, have prevented many persons from being admitted to psychiatric facilities and assisted those discharged from such facilities to remain in the community.

Mental health treatment has advanced significantly over the last 10 to 15 years. Indeed, this is one of the most rapidly changing areas of health care. In the final analysis all of our efforts must be brought to bear on ensuring that our Ontario system keeps pace with the changing nature of treatment and continues to provide the very best care available.

The steps we are taking with respect to the service provided in the golden horseshoe are consistent with this objective. By phasing out Lakeshore as an inpatient facility and making use of unused available capacity in modern facilities, by rebuilding Whitby, and by enriching outpatient and community-based programs, we will significantly improve the quality of mental health services available.

**Mr. Conway:** Mr. Chairman, I have one or two very general questions to begin with. It is my understanding that we have access to the minister at the end of our hearings if such is required.

I appreciate your comments here today. You have indicated basically that the position has not changed substantially from that of January 22, although you are indicating a certain flexibility on certain of the programs that have been much in the news with respect to a movement away from institutions—I am thinking of the alcoholic program, for example—and I appreciate that. I want to ask two questions to begin with, and then I will turn it over to others.

The first is, reading your statement again this morning, on January 22, the time you announced the closing and the course of action you were going to take—and in that connection I really must take some exception to the slide show, all of which was interesting, but I think clearly there is an effort here to depict some kind of straw case, if not a straw man, in that the suggestion that somehow those who are fighting for the saving of Lakeshore are fighting for a decrepit 89-year-old public hazard of a building when they have the option of this spanking new facility at a cost of \$41 million down the street from this building.

It is, I think, certainly an impression that reasonable people could gain from that slide show and one that I think should be strongly resisted at the outset, simply because I don't know of anyone in this room or out



of this room who would argue that the facility presented to us in those slides represents the kind of facility that any of us in this room or in the community wants to see sustained. It is, from my point of view, and I am sure from the point of view of all reasonable men and women, the basic position that the 89-year-old facility must be, if the decision is taken, either completely renovated or rebuilt entirely, and that 89-year-old facility, which was paraded across the screen in 10 or 15 highly unfavourably comparative shots with respect to Queen Street, is not something which in terms of plant, bricks and mortar, any of us is here to fight for.

I think that must be clearly understood. The concept of Lakeshore is certainly at issue here, but that series of buildings is widely and I think almost unanimously regarded as exactly an 89-year-old structure that is in very serious need of repair and replacement.

In your statement of January 22—and I want to elicit a comment from you—you indicated you had begun a review of your psychiatric services program, particularly in the institutional sector, and you had commissioned the McKinsey study; which as you say was received in the initial draft in September 1977, and the final report was available in January 1978, during which time an interim ministerial review was initiated.

[4:15]

Then you say in the statement, and I quote: "Our review was well under way when it was overtaken by budget considerations"—that's probably unfair, maybe I should just finish that sentence. "Our review was well under way when it was overtaken by budget considerations, including determination that there were more excess beds at the Queen Street Mental Health Centre," et cetera. I find that sentence is a little discordant in itself, but that's for Mr. Lawlor and other grammatical experts to comment upon.

What I want to deal with is that first clause that the review was well under way when it was overtaken by budget considerations. My question is simply this: Did the budgetary position of this province as known to you in that time frame, presumably the first half of 1978, really determine above and beyond all else the kind of options which you as a minister were free to consider with respect to Lakeshore?

Hon. Mr. Timbrell: I think you have to look at the whole statement. I don't think you can take just the first clause, as the member suggests. The fact of the matter is

that having received McKinsey, the recommendation to rebuild both Lakeshore and Whitby necessitated a review of our likely position in the future in terms of the availability of capital funds. It was made clear in my discussions with my colleagues that that was highly unlikely in the foreseeable future.

McKinsey had already, in the report, identified a surplus capacity at the Queen Street Mental Health Centre which, as you know, has been a subject of some debate; one group putting out a fact sheet saying so many beds are available and another version saying no, the potential is this many available. The fact of the matter is that the entire Lakeshore inpatient population can be accommodated and accommodated well at Queen Street. I guess a more accurate way would be to say they were interwoven.

It's an interesting case in point, in fact, that when Queen Street Mental Health Centre was designed, that is when the planning to rebuild Queen Street began a decade ago, it was based on certain assumptions at that time about the need for beds in the future, which assumptions were off by a country mile, inasmuch as in that decade further changes in the delivery of mental health care have continued to come about, including the continued growth in community-based and outpatient services and decline in inpatient. So really they were intertwined, I guess is the best way to put it.

I don't think you were able to be at the press conference in January when I announced this. I acknowledged that clearly what I was presenting was a report which at face value refuted the actions I was taking. I then went on to explain the various factors I had to consider in evaluating that report, including the fact that in fact there are more beds available at Queen Street than that report indicated and that report never even took into consideration the excess capacity at Hamilton Psychiatric Hospital. So the current situation, wanting to get the best use out of Queen Street and Hamilton, and looking ahead to the future, indicated that the best decision that could be made in the interests of the patients would be to close out the inpatient programs where they are and to move them.

Mr. Conway: In that connection, this study, for a lay person, is a very impressive document in all of its five volumes, and the allocation from the public purse to pay for it is equally impressive. It was done by probably one of the most notable private consulting firms in the health care business, and it does



build a very impressive case with respect to the reconstruction of both the facilities.

What I am interested in hearing you do for us today or at a later date is to refute on grounds of health care policy—not dealing for the moment with budgetary policy, which some of the cynics, myself included, are likely to believe is the sole purpose for most of this decision—to refute on grounds of this government's health care policy the kind of recommendation based on the sort of evidence presented in that report which led to their very considered and well-reasoned opinion that Lakeshore should be rebuilt as is.

**Hon. Mr. Timbrell:** Where would you like to start?

**Mr. Conway:** Wherever you wish.

**Hon. Mr. Timbrell:** Looking back again over the last 10 or 15 years, if you look at the way the system has developed over the last 10 years, and look even at some of the assumptions which were made a decade ago, including assumptions which led to the size of the rebuilt Queen Street Mental Health Centre, clearly the emphasis continues to be away from the inpatient facility. Obviously that's not to say that you ever reach the time when you won't need inpatient facilities, because you will always have to have them.

In that time we have also had a growth in the number and size of inpatient facilities in community general hospitals. In fact, in the particular catchment area that we are referring to, the growth in the last decade has been considerable if you consider just the region of Peel alone, quite considerable in the last decade, and yet the inpatient population of Lakeshore hasn't gone up, it's gone down. It's been part of this trend of diminished use of inpatient care, reduced average length of stay in psychiatric hospitals and growth in community inpatient facilities and community programs.

I think it would be a mistake to look at McKinsey just in terms of Lakeshore because it did deal with broader questions than just that. In the McKinsey report they made certain assumptions about bed availability at Queen Street which underestimated the amount of space actually available in Queen Street, space which is more than adequate to accommodate all of the inpatient population at Lakeshore. As I mentioned earlier, they did not take into account the excess capacity of approximately 100 beds at Hamilton Psychiatric Hospital, which is again a much more current facility in terms of the age of the building and the layout and the facilities available to their patients.

So it seems to me that, budgetary considerations aside—that is, restraint budgetary considerations aside—it just would make sense to make the best use of the most modern facilities you've got in the province where you've got the capacity, rather than refurbishing or rebuilding just about the oldest facilities you've got in the golden horseshoe area. If I remember correctly, McKinsey's projection of bed need at Queen Street for 1987 was an additional 40-some beds, or something?

**Mr. Jappy:** Yes, 445 by the year 1985.

**Hon. Mr. Timbrell:** It's difficult to say whether that's correct or not, given that projections of a decade ago are suspect; the projections resulted in Queen Street being built with a 700-bed capacity and current population is considerably less, enough to accommodate Lakeshore.

Even without budgetary considerations to do with the need to hold the limits of increases in spending, I think, given all that, you would want to make the best use of what's available before you start committing sums of money perhaps to overbuild. That is essentially it. In the final analysis, I quite agree, it has to come down to what is in the best interests of the patients.

**Mr. Conway:** If, in the absence of severe budgetary constraint, you as minister were facing a situation of having the dollars that you reasonably wanted to run your ministry, as was the case for many years, would you, under those conditions, be prepared to implement McKinsey?

**Hon. Mr. Timbrell:** I don't know that there was ever a time that the ministry got all the money it wanted—ever.

**Mr. Conway:** Sure there was, sure there was.

**Hon. Mr. Timbrell:** I doubt that.

**Mr. Conway:** Just ask Matt Dymond.

**Hon. Mr. Timbrell:** Even Dr. Dymond, I am sure, had years when he had to cut the cloth according to the pattern.

I think, at least I would hope, and this is hypothetical of course, that given those facts about the size of Queen Street and the facilities available—and I don't know whether you have been through both but I invite you to go through both; I certainly understand your concern about the slide presentation but I assumed that many members would not have been through both and I thought you should have a visual presentation—given those facts then, it would just make good sense to make the best use of the facilities available.

Even if this non-existent time you are trying to portray ever existed when money was boundless, even if money were boundless, you would spend that money on something else if you can look after the needs with facilities already bought and paid for.

**Mr. Conway:** Since there is no question that a very substantial part of your case rests on not only the capacity of principally Queen Street to deal with the additional patient load but also the ability of the surrounding community to accept its part of the transfer, how do you as minister respond to the position taken by certain members of Toronto city council and others in the area of the Queen Street Mental Health Centre that the prospect of the transfer of the Lakeshore patient load and many of the programs to Queen Street not only will potentially overload the facility but will create a situation in that community which is from their point of view quite intolerable? I hope that is something that we as a committee will be able to examine more fully with others, particularly from the political community here in Toronto and people in the area affected. But how do you respond to that kind of criticism?

**Hon. Mr. Timbrell:** Even among health professionals you are going to get differences of opinion as to what is appropriate on any given question. Looking over the list of witnesses who are going to appear before the committee, I am sure you are going to hear quite a range of opinions about what size psychiatric hospitals should be and should they be very large or very small, and also about the appropriate philosophy.

I, as a politician who isn't a health professional, am in the position of having to make a judgement after looking at the competing arguments—and I suppose in this case there were the competing arguments of Mc-Kinsey versus the figures and the information provided to me by my staff as to what alternatives were available. The question is, what do you make the judgement on? That is, what guides you?

Certainly my first consideration is what is in the best interests of the patients. Obviously I can't escape budgetary considerations; even if we were in a time when money was supposedly plentiful or boundless, every year you would still have to make a decision as to your priorities and where to spend the money available.

[4:30]

I would say to those councils that certainly I understand and appreciate their concern. I would hope some of those councils

in the future also would show their concern by maybe changing some of their bylaws that deal with the provision of services in the community. Given their apparent interest in psychiatric care, mental health care, I would hope they would take it that far in the future. But I guess I would have to respond by indicating that all of the information available to me indicates the decision taken is in fact in the best interests of the patients and of the community.

**Mr. Conway:** Just a final point: Where does the projected patient load at Queen Street, when the proposed transfer is completely effected, leave Queen Street in terms of overall patients relative to other psychiatric hospitals? What kind of a patient load will it have relative to others?

**Hon. Mr. Timbrell:** Size?

**Mr. Conway:** Yes.

**Mr. Jappy:** We are looking at an outside patient load of approximately 600, which is comparable to London with 500, Whitby with 500 and Penetanguishene with approximately 600. With the 10 facilities left in the provincial psychiatric hospital system, two small ones are up north at Thunder Bay and North Bay, and the others are approximately around 450 to 600 beds in size. So it doesn't go wildly in one direction.

**Mr. Lawlor:** Mr. Chairman, a couple of initial points: Before these hearings are over I would invite this committee, or such members who are so disposed, to visit personally the facilities in question at Lakeshore and at Queen Street and have a look at them ourselves, if we can possibly work it in, rather than relying on the somewhat tendentious slides. The second thing I wish to bring to the minister's attention is that there are numerous questions on the Order Paper. You have indicated, or someone has indicated, that interim answers are going to be available some day.

**Hon. Mr. Timbrell:** They were sent to the Clerk's office today. I am going to send you the bill. I am not sure how many were there, but we are working on them as the answers come up. I didn't count them all, but a great many of the large number, which are costing great sums of money to answer, were filed with the Clerk's office today.

**Mr. Lawlor:** Oh, Mr. Minister, if it would save you great sums of money which you could place in some partial renovation at Lakeshore, you need not answer my questions; they are asked simply—



Hon. Mr. Timbrell: I thought they were rhetorical.

Mr. Lawlor: Well, not rhetorical, no, no. They were impertinent and seeking to annoy you and to stir you into some activity.

Hon. Mr. Timbrell: I sent you back a note saying I liked the book better.

Mr. Lawlor: Yes, you did.

Hon. Mr. Timbrell: It's a good book.

Mr. Lawlor: The psychiatric condition is more widespread than one would have anticipated, you know. And that's one thing I want to talk about here initially. I am going to put it bluntly to you. The McKinsey report is an excellent one, and under anywhere close to normal circumstances would have been implemented. The reason you sat on it for a year is because you are in agreement with it and you wish to implement it, but the fact of the matter is that capital considerations became overwhelming. It had nothing to do with mental health care. The mental health care of the province suffers thereby and you are forced to concede to the Treasurer (Mr. F. S. Miller) in this particular regard.

That's the way I see it; I am sure that's the way my party sees it. It's regrettable. I would wish you would beat your breast a bit and say you believe it's regrettable too.

I don't like the next step, which I broached with you in the past and which is in the questions I asked you. You don't have to do it that way, nor did the McKinsey report, strictly speaking, recommend that you make one lump-sum, \$25 million or whatever it might be, complete rebuilding of that facility.

The McKinsey report has documented coercively and monumentally the need for the continuation of Lakeshore, no matter about Queen Street. They are perfectly willing to concede the potential of Queen Street. They took it all into account, and the position of Whitby. True, they did not direct their attentions upon Hamilton, where you come up with 100 beds; but Hamilton is somewhat removed from the health district and from the health councils and from this particular area, and from friends and neighbours and relations who might just possibly want to visit some of relatives in such an institution, which is supposed to be therapeutically valuable to people who are in this condition; possibly the single, most important thing, even more so than the psychiatrist. So you take them off somewhere at the end of the world simply to meet your numerical demands.

Had it not been for that capital picture, you would have gone forward with this

scheme on some kind of rational basis. I would suggest and I would continue to suggest, and I have not got an answer from you yet to the question as to whether you won't consider, and isn't it worthy of consideration in light of the full weight of this report, that you phase in the development. At the end you need not have a 450-bed hospital, as they suggest, but you might very well end up with a 150-bed hospital.

I am trying to bend over backwards to make the most concessions to common sense in this particular situation. That does not have to be erected overnight. It does not have to be done immediately. Your own report here, the Government Services report indicates that that hospital would last at least for another 20 years pretty much in its present condition, without a great enormous expenditure. It's not as though it's decaying in front of our eyes. You have poured millions into it in the past 10 years and even within the past couple of years. We will hear evidence that the buildings are sound and utilizable and that it is a great shame not to keep them at least, as I suggest, until such time as new buildings can come on stream; not as large, not covering as large a catchment area, but will absolutely on the basis of the projections and statistics that you have, be necessary in the next five years.

Therefore, I say that over a period of five or even 10 years, why not phase in new buildings at some portion of the ground. If you want to release other portions of the ground for other purposes, so be it.

For years I have asked succeeding Ministers of Health to utilize part of those grounds for senior citizens' housing, or for public housing, or for some form of development along the Lakeshore. I can show you letters—I have brought them here today—from Frank Miller and back to Matt Dymond, saying, "No, these are precious grounds. It's the most sacred place in the province. It may not be impinged upon." I suggested once that they build out into the lake, since they thought the land itself was so sacrosanct. He refused to do that; he felt that the lake contained some elixir too, I suppose. I don't know.

Mr. Conway: Tories prefer to walk on water.

Hon. Mr. Timbrell: Then you criticize us for not knowing how to swim.

Mr. Lawlor: All these nostrums, all these Delphic oracles, are outmoded and retired. Suddenly, and by fiat, in January of this year, without consultation with the community, by a completely unilateral action which you are careful today in your statement to repudiate



but which is a fact of the matter, subsequent to the event, you begin to talk to people, and that is all to the good. It would have been nice had you done so at a little earlier time.

All right. I would suggest this phasing. Suppose you started with a 50-bed unit, which would not cost very much money, and then the next year add 25, and construct in such a modular fashion that you can interleave the units as they come on stream over a period of time such as your budget will afford. Half your headaches would disappear overnight.

You've already conceded a couple of the points, and God bless you for it; namely, the alcoholic unit. There isn't facility for that. We will hear from Dr. Maharaj, no doubt. You're looking for a school. What are you going to do? You're going to revamp an outmoded school and make it into wards.

What the devil is the cost of that going to be, and what community difficulties do you think you're likely to encounter in this particular context? You're asking for trouble. If you erect in the next couple of years a 50-bed hospital there you could make provision within that complex for the whole range of outpatient services and you wouldn't be out fencing around and twisting and turning as you're doing at present, and will continue to do because you won't find these facilities.

Three years ago I was involved in another quarrel, a real fight with your ministry. I am sure it would have been much more easily solved had you been the minister at the time, Dennis, although I am beginning to doubt it. It was over the child and adolescent care unit. We set up a community committee and attended many meetings. To this day we've never been able to find a satisfactory place or institute in the area, school or no school, or anything else, to accommodate that unit. It's still on the psychiatric hospital grounds and will be and there's no move—it's taken out of your jurisdiction in any event—no real move. There aren't that many buildings satisfactory to those purposes available in the Lakeshore. It's an industrial area and you don't want barns housing therapeutic patients, for heaven's sake. So you'll end up utilizing not just the workshops and the rehabilitation services, but a very wide range.

In the course of these hearings, as you retire tonight and mull it all over, give some thought to this. We could terminate these hearings rather quickly if you would concede my major points. We could go on our way and do something else, not nearly as valuable of course, but something else.

This report goes to great length to prove the weight, the very great numbers of human beings in this society and in Ontario and throughout the western world, who are afflicted, disturbed, either neurotically or psychotically, whatever these words happen to mean, but in any event find difficulties in getting along with other human beings, or adapting themselves to their jobs and to this world. Their lives are fraught with difficulties, and it's worsening. The western world—and this is my gloomy picture which I wrote the poem about—is in deepening malaise; there's a very great sickness about.

As to the figures given in the report, I wouldn't accede to this, but some experts estimate the number of mentally ill people at up to 50 per cent of the population. Then they go on to say that whether it's 10 per cent, which is fairly acceptable, or 50 per cent, the proportion of people who could be mentally ill and who could need some form of psychiatric care is very high. We encounter that every day—prejudiced people, awkward people, people who are irritable, people who are full of anger, people who hate everything and everybody. It's very widespread and very deep.

That's where you start. How many of these people are at present being looked at? Less than five per cent. There's a great need out there which hasn't even begun to be met.

[4:45]

A second point: On top of that, what does this report say about your present facilities—things as they are, even if Lakeshore were fully continued, not in terms of the capital expenditure but in terms of the necessary projections and expansions that would be needed to accommodate this very large number of people in difficulty.

McKinsey said we're at an absolutely minimal level now as compared to every other major jurisdiction in the world, and he sets forth the statistics; I won't bore you with them, they're all there in the book. In chapter four, I do think I will refer to one:—"Compared to other jurisdictions, greater Toronto has a bare minimum of PPH beds." We'll come, as a sidenote or footnote, to the necessity of PPH beds of the psychiatric hospital beds over against the psychiatric units.

I want to explore, and will ask you to explore with me, whether you agree with the philosophy of this report as to the kind of care and range of care that these distinctive types of entities are able to provide. I will stick to the PPH at the moment. "To the best of our knowledge every sizable jurisdiction in the western world uses some form of

state-run psychiatric hospital to care for its most severely ill psychiatric patients. Both Ontario in general and Greater Toronto in particular have fewer beds per capita than any comparable-sized or larger jurisdiction."

There's an enormous need out there, the need being met absolutely minimally, and the minister proposes a fortiori to cut back even on that, in effect; just simply not to provide the range of services in face of his own report, in face of a document which has enormous authority. What does he say he does that on? He does it on political grounds. I don't think it's particularly dislike of myself, although I think it's probably increasing, I hope, but the political grounds I am referring to again are straight money and nothing else is the moving factor in this particular context.

I won't take much more time at the moment. I have many questions here in front of me. I think it's only fair to allow other members to get in. We can't take all the time, can we, Sean?

**Mr. Conway:** We never do.

**Mr. Lawlor:** I'll desist for the moment.

**Mr. Chairman:** Do you wish to answer, Mr. Minister?

**Hon. Mr. Timbrell:** I suspect, Mr. Chairman, that a lot of the points made by Mr. Lawlor will be repeated in one form or another by other members and I know I'm going to have a chance to respond towards the end of the committee's deliberations. Between now and then you will hear from a variety of people, most of them people more learned in these matters professionally than either the member for Lakeshore, the member for Renfrew North or myself. I will predict there will probably be some considerable disagreement among them too, as is often the case, that for the same goals, namely the best possible care of our populace, different answers will arise.

Certainly, in reviewing with staff the submissions we've had regarding such things as the alcoholism unit and outpatient and occupational therapy and so forth, we concluded we have to leave that option open and we have to examine those arguments and not close that door entirely about leaving them at the Lakeshore site. I don't know how the honourable member arrives at the number 50. Why isn't it 75 or 25 or 100?

**Mr. Lawlor:** Well—

**Hon. Mr. Timbrell:** No, I'm trying to make a point.

**Mr. Lawlor:** I want to make it easy for you to do.

**Hon. Mr. Timbrell:** When you make the evaluation of facilities available, and of the services that, of course, are required to back up a complete inpatient program, then I think looking at now and the foreseeable future you would make the kind of decision I did in balancing the competing arguments that were coming to me.

I think that in another respect the McKinsey report isn't perfect, in that I don't think you could credibly say it gives full recognition to the range of community mental health services that have been developed in these catchment areas or others. In that regard I think we stand well ahead of most of the jurisdictions that were looked at. That was a problem. I know you've often referred to the California experience. In California's case, they in effect turned the people out and, after the fact, tried to cope, whereas in Ontario, over the last 10 to 15 years, the shifts in the system have compensated one for the other, with greater emphasis on mental health facilities at the community level.

**Mr. Lawlor:** You don't want to emulate—

**Hon. Mr. Timbrell:** I'm not emulating. That's the point I'm trying to make, that whether it's been at Oshawa General or at North York General or, wherever, we have established in the last decade a considerable range of community psychiatric programs. I think the number stands at 68 or 69 community psychiatric units which account for close to 2,000 beds now, which didn't exist in the early 1960s—I'm not sure what particular year you would pin the development of them but it was in the mid to late 1960s—and about 70 community mental health programs which again didn't exist 10 or 15 years ago. Those numbers are growing.

I think our record in that area has to be taken into account and put in with many of the comments of McKinsey. On the specifics you referred to, the numbers and so forth, I'd be glad to respond to questions about numbers, amounts of money spent on maintenance or renovations over whatever period of time. I may say that in determining to keep the land for public purposes, I would be prepared to see discussions pursued with other levels of government about some of the projects you referred to. With respect, I don't think those have ever been drawn to my attention in the time that I've been minister, but I'm certainly prepared to see them pursued to see what can be done, because, in fact, since the land was conveyed to the crown in 1888—

**Mr. Lawlor:** I thought there was a will that forbade you from doing what you're



trying to do, but I went and looked it up and there isn't.

**Hon. Mr. Timbrell:** So did we. We heard you were looking. We checked too. No, in point of fact there is no covenant. Since the land was first conveyed in 1888, portions of it, as you know, have been hived off in the past for the teachers' college, the filtration plant, the community college has an interest in there now, lands have been taken off for road widening, this sort of thing in the past, so I'd be prepared to see some consideration given to other public uses of portions of the land.

You said "suddenly" and "by fiat"—however one is supposed to pronounce that; it's now pronounced lada in some quarters—the decision was announced. I don't know how you could make the kind of decision that I had to make except to keep your own counsel and then make the decision and go with it. It's how the followup to it is carried out that I feel is very important. How are we going to determine where the additional community mental health—

**Mr. Lawlor:** All you are saying is that you learned from Frank Miller.

**Hon. Mr. Timbrell:** All I'm saying is that under our system we have mayors and controllers and ministers and the rest of the government who have to make decisions. I have been in politics since January 1, 1970, so I'm essentially a politician of the 1970s, and I've seen this business of participatory democracy used and abused. I support it very strongly in the positive sense, not in the sense of using it to avoid making decisions or to fudge issues. I think you and I would agree, if we looked back over the last 10 or 11 years since that expression entered our vocabulary, that has happened and it has happened many times.

Since making the decision, recommending it to cabinet, getting approval, we have involved the public extensively in the preparation of and discussion of submissions for the expansion of community mental health programs for the Lakeshore catchment area, and also of course covering outpatient services already on site. It's as a result of those submissions that we are in fact at this point prepared to say the land will stay in public ownership and the submissions suggesting certain services be retained will be considered, and obviously they will be considered on the basis of comparing against the alternatives, costs, location and so forth.

I think that kind of public involvement can be very productive. I'm told that a good range of submissions has been received. It's

been very well carried out in the various communities. In my rebuttal I will try to group together various points that require rebutting. I don't think the honourable member and I are that far away from one another, except that I don't think—

**Mr. Duksza:** You are going to agree with him?

**Hon. Mr. Timbrell:** No, no, I didn't say that.

**Mr. Duksza:** Then you are far apart.

**Mr. Lawlor:** I would say like the Caribbean Sea, not the Pacific Ocean. May I ask a couple of questions?

**Hon. Mr. Timbrell:** Sure.

**Mr. Lawlor:** The special orientation centre—

**Hon. Mr. Timbrell:** Observation unit.

**Mr. Lawlor:** Is that the same thing? I thought it had to do with retarded. Is that being maintained at Lakeshore; going to be kept there?

**Hon. Mr. Timbrell:** That depends on the result of the discussions with ComSoc about the retardation unit. The staff have been talking with the Metropolitan Toronto Association for the Mentally Retarded about that as well.

**Mr. Conway:** Any indication as to what might happen?

**Hon. Mr. Timbrell:** Not that I'm aware of.

**Mr. Conway:** Any time frame on when we could expect it?

**Hon. Mr. Timbrell:** No.

**Mr. Conway:** How many meetings have occurred?

**Mr. Jappy:** Approximately three meetings with ComSoc and there's been a review done by the Metropolitan Toronto Association for the Mentally Retarded just last week.

**Mr. Conway:** Were you party to those discussions, Mr. Jappy?

**Mr. Jappy:** No. What has happened is that we have asked a couple of caseworkers from the retarded association to see if there were any candidates for group homes throughout the city. We understand there are a few openings at this point in time. We have also been in communication with Community and Social Services to determine whether some of the people in that particular unit can be placed in other ComSoc facilities at this time. I'm sorry, we have no firm answers today.

**Mr. McClellan:** In view of the shortage of facilities for retarded people in Metro Toronto that's not surprising.



**Hon. Mr. Timbrell:** We made it clear from the beginning with any service which, it was determined through this decision-making process, should be relocated elsewhere, that if something was not found by a particular point in time or date the thing was we wouldn't just cease operations.

**Mr. McClellan:** Do you have a time frame then on this?

**Hon. Mr. Timbrell:** No.

**Mr. McClellan:** Because, as you know, the facility for Toronto for retarded people is Huronia Regional Centre in Orillia, and there's still an enormous problem in Metro, unique in the province, around the development of alternative facilities here in Metropolitan Toronto.

**Hon. Mr. Timbrell:** You would be more familiar with it than I, but as I recall there have been discussions with this committee during the estimates of my colleague and elsewhere about various proposals that ministry has made over the past couple of years for facilities in Metropolitan Toronto for the retarded. I'm not going to presume to answer on an area I really know very little about, other than in my own constituency where we do have a residence recently opened.

[5:00]

**Mr. McClellan:** I would be willing to wager that you will not be able to find alternatives, because the alternatives, which I won't go into, have not been built. They are on the drawing board, but they haven't been completed or constructed.

**Hon. Mr. Timbrell:** We are not under any gun on that either.

**Mr. Lawlor:** I have just one more question at the moment. You stress the falling off or decline of beds over a 10-year period. You will concede the other way around that there is a hard core, in any event, of mental patients, that part of it must be reflected in the population and the population increase. Secondly, the graphs that we have in front of us from the union brief and from the McKinsey report show there is a constant admission all through that 10-year period, but that Lakeshore in that period has had an 87 per cent increase, much greater than the other two hospitals in this regard. That is all to be taken into account too?

**Hon. Mr. Timbrell:** Yes, there is a hard core. I don't know how large it is. In the 27 months that I have been minister, the inpatient population has dropped from close to 5,000, I think, in early 1977 to the point where it is now around 4,000. That hasn't

been a promotion of the diminution of psychiatric hospitals in that period.

**Mr. Lawlor:** Dennis, there are many explanations for that; some not favourable to your ministry.

**Hon. Mr. Timbrell:** I concede that there is a hard core. I don't know whether anybody knows how large a core it is.

**Mr. Duszta:** Mr. Minister, one of the things which struck me about what you were saying in your presentation of the rationale for closing Lakeshore is that you used consistently terminology and the model of the community psychiatry, while in effect that is a misleading statement on your part because the reasons for closing the hospital have less to do with the better treatment, better approach to the community, and more to do with basic political decisions, which is a need by the government, obviously, to save money at all costs and to hell with the need for psychiatric services.

Clearly, we cannot possibly finish today with the questions I have to you. I just want to open some of the subject from the conceptual point of view, because you brought it up. One of the rationales you used, the major rationale, is that this is a significant move by the government to provide community-based psychiatric services. In fact, I can even quote some of the things you say. You say there is a shift from the inpatient to the outpatient care. You have said that modern treatment methods place a greater emphasis on the care of patients in their own communities wherever possible and on programs that serve the needs of the patient in the community.

You also say there is a growing emphasis on community-based treatment. You also say that of course it is all shared by everyone. But if you look at exactly what you are doing, and I will try to develop this point, it isn't that you are shifting towards the community-based provision of psychiatric programs; what you are doing really is combining two large hospitals into one, you are combining two sets of programs into one, you are combining two catchment areas into one. So instead of having Lakeshore Psychiatric Hospital, with its catchment area of over one million, and the Queen Street Mental Health Centre, with under one million, you are now going to have one large hospital that will provide the services, with some parts of it too now to go to Hamilton psychiatric; a very large area, probably a catchment area of approximately two million people.

A very large hospital, which now will easily have 600 patients, will probably move, if we follow the figures of the McKinsey report, to much bigger within a decade. For this you are saying that you will also provide some money, \$1.3 million or more; and you have announced all sorts of things that you are going to do to provide so-called community-based psychiatric services. But you are providing those extra community services to substitute for what you are going to cut off to start off with, so I cannot understand how you can even talk—

**Hon. Mr. Timbrell:** Mr. Chairman; with respect, that is not correct.

**Mr. Duktzta:** Let me just first set out the points of view I want to develop, because I have some data and I want to question you in time, or the people from your ministry or from the Lakeshore Psychiatric Hospital, to determine exactly how much we are losing in terms of outpatient services which are being provided directly from the inpatient units or the facility of the hospital itself, in comparison with the money you say you are saving and will give to the community.

As you know, and just as an aside, a lot of the outpatient treatment in a psychiatric hospital is provided directly in the hospital itself. People come to the day-care centre, people come to the occupational therapy unit, people come for industrial retraining; all those things. Even though they may not have been as thoroughly developed as one would wish in some psychiatric hospitals, they are there. People come and get medication directly on the wards, for example, it still goes on. So when you count that up, someone has to pick up on those things; so you pick up, you say, in the community. In effect you are simply shifting the money from the hospital to that.

**Hon. Mr. Timbrell:** Mr. Chairman, with respect, we have already said that occupational and industrial therapy programs will be retained; the alcohol program will be retained; all of the outpatient services that are at present operating in the hospital will be retained. As to where—

**Mr. Duktzta:** Yes, my point, Mr. Minister, is where are they going to be retained and how? When we talk of community psychiatry, it does mean, in fact, a community. Now let me develop this point before we go into more detailed questions.

You state this is a move to the community psychiatric approach. I am saying to you my thesis is you are merely coalescing two hospitals into one, which is some-

thing quite different. It's not a particularly modern approach; it was in fact tried in the late 19th century, centralizing. Maybe the best thing to do would be to combine all hospitals into one major hospital. If that is what you want to do, then you should come out very clearly as to what you want to do.

**Hon. Mr. Timbrell:** No, hold on a minute; just hold on a minute there.

**Mr. Duktzta:** One large total institution.

**Hon. Mr. Timbrell:** The green paper you put out last year advocated that; I have never advocated that.

**Mr. Duktzta:** No.

**Hon. Mr. Timbrell:** Yes; the one big hospital board, yes; look at your paper, page 32 I think.

**Mr. Duktzta:** I remember my own paper at least. Now don't give me that nonsense.

**Mr. Breaugh:** Oh, Dennis, don't be silly; a board is not a hospital.

**Mr. Duktzta:** Not on page 32 anyway. It was not one large hospital, very specifically.

**Mr. Breaugh:** Do you know the difference between a hospital and a hospital board?

**Mr. Chairman:** Order.

**Mr. Breaugh:** I'm just trying to help him out.

**Hon. Mr. Timbrell:** You'd be surprised by the time you read it.

**Mr. Duktzta:** It's not on that page to start with; so you didn't read it very properly.

No, to get back to what you want, clearly; if you are coalescing the two hospitals, then you should stop pretending that this is the movement to community psychiatry. There are some questions you have to look into on this whole concept of a move towards community psychiatry.

I worked in the psychiatric setting, before election, for a number of years. I happened to have worked at the Lakeshore Psychiatric Hospital and I happened to have worked at the Queen Street Mental Health Centre. In the late 1950s and the early 1960s, there was a decisive movement, of which you are well aware, Mr. Minister, in the field of psychiatry and provision of psychiatric services advocating that the psychiatric treatment must be delivered in the community.

All the people who worked in psychiatric hospitals took those decisive steps in terms of emptying the hospitals, providing them with support systems—or attempting to provide them with support systems, all within



the financial limitations the government then provided as always—in dealing and helping and treating people in the community, in the general hospital units, so that there was provision of the general spectrum of the services, with the psychiatric hospital then being the last resort of the treatment, but at the same time a fulcrum for the broad provision of psychiatric services; which would range from a person seeing someone in a social agency—a priest, a general practitioner—to psychiatric units in a general hospital, to a rehabilitative, custodial or other type of treatment, backup facility provided by the psychiatric hospital.

It was always perceived that a psychiatric hospital would be in effect a fulcrum, and a necessary fulcrum however much we may disagree with it, in providing the broad, community-based spectrum of treatment we now consider a modern approach to psychiatry.

If the fulcrum is removed, if that basic focus is removed from this provision of services, then all the services in the community are in fact endangered. In a way one does not realize how important the role of a psychiatric hospital has been—like Lakeshore or Queen Street or Whitby—in terms of integrating the services which are now being provided. You will hear soon enough that the general hospitals, by the very nature of their practice, by the very nature of their structure, have never been able to provide a full spectrum of inpatient services, whereas the psychiatric hospital can.

You have recognized this, in a sense, if not in what you say at least in realizing that you cannot abolish the hospitals. So what you have done, in fact, as I mentioned before, is simply combine the two into one; which has its own immensely negative characteristics, one large total institution providing psychiatric care for a very large area.

There is one other point I would mention in these very general remarks. You cannot in effect provide a complete set of psychiatric services in a community, because there is ultimately a certain group of individuals and people who must have an institutional type of setting; whether on a partial basis or a long-term basis depends on the individual concerned. It has to be there, within the reach of the community-based facilities; within the social contact of that individual who is temporarily or otherwise part of the psychiatric hospital.

You cannot do what has been done in the past in Ontario and other provinces, where

individuals had to travel up to 900 miles to go to a psychiatric hospital. In our case it may only be 100 miles or so, but nevertheless there is a danger that the individual loses his social contacts and contact with his family. That is another thing which could happen.

If you do not have this unit within the reach of the people, you endanger all the community-based programs which exist already in the community. That, I think, is what is being done right now. Under the guise of what is called community psychiatry, the ministry has coalesced the hospitals and hopes that the psychiatric patients who have been in some of the programs—inpatient and outpatient—will simply go away.

But the minister knows that they merely go to the special care homes, nursing homes, boarding homes in the community; they sink without a trace, without treatment often; they become invisible. Without treatment, without rehabilitation, without industrial retraining, without sheltered workshops; they simply go into the community and produce problems for the community and for themselves. They do not disappear, they are merely out of our sight. Any move to disturb that thing, instead of improving that network, but merely going back again to the totalization of treatment in one unit, emphasizes, exacerbates and accentuates the problem we already have in dealing with long-term psychiatric patients.

I think a lot of people want to make fairly general remarks in response to your fairly general statement. I will have a set of questions on details whenever the minister comes back, or for the members of your staff.

**Hon. Mr. Timbrell:** You may as well start now.

**Mr. Duksza:** No. Other people want to cover other things too, so I will come back if I may.

[5:15]

**Hon. Mr. Timbrell:** Mr. Chairman, I think what I will do is perhaps reserve comment on most of the remarks inasmuch as there are certain key themes that will recur.

I must take some exception; one has to make some allowance for the fact this is a political arena and one expects certain exaggerations, but when the member says, or suggests, that I in effect have said—and I think I am paraphrasing and maybe not quoting him properly—"to hell with psychiatric services," I take some considerable exception to that.

**Mr. Duksza:** It was extrapolation.

**Hon. Mr. Timbrell:** It was exaggeration; in fact it was a fabrication almost.



**Mr. Duksza:** Almost as much as what you say that I said in the report that I gave to the party.

**Hon. Mr. Timbrell:** I will check that; maybe it is page 43.

**Mr. Cooke:** The minister is the biggest offender on what he is accusing the doctor of.

**Hon. Mr. Timbrell:** Oh, really.

**Mr. Cooke:** That's right.

**Mr. McClellan:** No I think Stephenson.

**Mr. Conway:** I think Stephenson.

**Hon. Mr. Timbrell:** Well maybe you would be specific; I would love you to be specific.

As I say, Mr. Chairman, the themes will recur; but in point of fact if you look at your argument, really what you would be saying is even if there were no change being proposed in the way we are to reduce the number of hospitals, or to enlarge the catchment areas, however you want to put it, you would in fact say that instead of there being 11 or 12 psychiatric hospitals there should be 24 or 30. In point of fact we have gone further than that by putting psychiatric services in the community hospitals, I think it is 69 hospitals.

We have spread the network through the community hospitals and through community mental health programs, not all of which are—sorry 55; I am corrected, 55; I am not sure where the other number comes from. At any rate we have 55 community hospital psychiatric units, and through those units and through the community mental health programs—not all of which are directly under a psychiatric hospital or under a public hospital, many of them are under community boards or through organizations like Mental Health St. Thomas, or whatever—we have actually decentralized, over the last decade, the provision of mental health services, I would suggest in a fashion broader and more comprehensive than most jurisdictions.

That is not to say there isn't still room for improvement. In fact when I referred the Mental Health Act to the Ontario Council of Health I also included in the terms of reference to the council and its task force the question of the provision of mental health services. Again, with respect, and I call into question not one bit your professional qualifications, but there are people with equally good or better qualifications who would differ with you on many of your points, and that is always the difficulty that we poor—

**Mr. Duksza:** That is unfortunate.

**Hon. Mr. Timbrell:** They are unfortunate?

**Mr. Duksza:** I consider that unfortunate.

**Hon. Mr. Timbrell:** For whom?

**Mr. Conway:** That has almost totalitarian implications.

**Mr. Duksza:** I think the minister is obviously aware that for some time now the ideal size for its psychiatric hospital, since the joint commission or our own Deutsch report, has been set at about 350 patients. People have said 350 to 600 patients for a psychiatric hospital. I am not going to quarrel with it particularly, but the smaller the unit the better it is in terms of services, of people knowing each other and how they operate, and the smaller areas they serve.

You have mentioned that the psychiatric units in general hospitals provide, in effect, the service that used to be provided by various psychiatric hospitals. You have a point, they do.

**Hon. Mr. Timbrell:** To some patients; they can't replace them entirely.

**Mr. Duksza:** No, they cannot. That is in fact the major point; the psychiatric unit in a general hospital has its own limitations. I give you two examples, or three points in which they differ from psychiatric hospitals: one, that the psychiatric units in the golden horseshoe, as you are fond of saying, do not have that many police admissions. Police admission, whether we like it or not, is a fact in psychiatric hospitals. Twenty-five per cent of admissions at Lakeshore are police-mediated admissions; and maybe as much as 33 per cent in Queen Street. At least a number of years ago probably one in three of the patients who came to Queen Street came with police or otherwise. Those are not the figures that you would find in St. Michael's or Toronto General Hospital, or in the hospital covered by the area which Lakeshore Hospital also covers. It is, in fact, very atypical. At the most it would be probably eight per cent; I would suspect it would be closer to two per cent. There is an immediate difference.

**Hon. Mr. Timbrell:** I will check with Mr. Jappy.

**Mr. Duksza:** Yes, do check with Mr. Jappy. I think the minister should know those things before he speaks on the provision of psychiatric services.

Not only is this one factor which is different between general hospitals and a psychiatric hospital, but also in terms of diagnosis. It is probably true that the people who go to psychiatric units have been tended to be diagnosed more in terms of the neurotic than psychotic, while the people

who go to the provincial psychiatric hospitals tend to be diagnosed as psychotic more than neurotic. It is a rough relationship.

The other factor, of course, and McKinsey speaks to it significantly, is that the patients who go to psychiatric hospitals are really people the general hospitals don't want to deal with. So there are various differences. Both have a part to play, but the point I want to again emphasize to you is the part they play with each other is in an organic relationship and to disturb, to remove a significant portion of this program at a psychiatric hospital like Lakeshore Psychiatric Hospital, will affect hospitals like St. Joseph's, Branson, North York, Peel Memorial, about 10 different general hospitals who have their own sets of psychiatric patients and problems. You just simply cannot remove this and put it all in one place far away from those hospitals which are dealing with it now.

**Hon. Mr. Timbrell:** I am not disputing the principles. I guess where we differ is on what is the appropriate way to use the available facilities and what is the appropriate way to organize existing services and to provide for the expansion of services. I am not disputing for a moment that there is now and always will be a need for the provincial psychiatric—I think McKinsey uses the generic term, the state hospital. That goes without saying.

**Mr. Duksza:** Why are you pretending in your statement that you are moving towards the community, when basically you are just making one large institution in Queen Street Mental Health Centre?

**Hon. Mr. Timbrell:** The point I am making is that the inpatient needs of the larger catchment area can be met at Queen Street. Some of the people, as you know, who were previously reliant on Lakeshore for their services, in Oakville and the eastern half of the region of Halton, will now relate to Hamilton Psychiatric Hospital and, in fact, that is probably more of a natural relationship in terms of the usual community links than towards Metropolitan Toronto; and people in York, the west half of York will now relate to Whitby, along with the eastern half of York. I would say that we are meeting the inpatient needs in the most modern facilities available, while the community or outpatient programs will stay in the community.

I haven't seen all of the submissions, for instance, that have come in for the new and expanded community health programs, but I am sure that a number of them have

come from community hospitals. I do know of a crisis intervention program in Mississauga that has come from a community hospital, that will be run by that hospital and—not trying to influence the judgement of my staff who are going to make the recommendations—I think it would be a good addition to that area to keep people out of provincial psychiatric hospitals who wouldn't necessarily have to go there.

In that same community, in fact, the number of community psychiatric beds is being expanded. A number of others will come from community groups, various affiliates of Mental Health Ontario, who will be totally community oriented and not institution oriented.

**Mr. Duksza:** Mr. Minister, you were not in the field and you are much too young to know what a dreadful effect the total institutions used to have on the patients who were incarcerated in them. Those institutions are much larger than the new reconstructed Queen Street potentially could be—600 to 800 patients.

**Hon. Mr. Timbrell:** My father was a psychiatric attendant at Kingston after the war.

**Mr. Duksza:** Then you know from his stories what effect it has when you sever the community roots and links of the individual with the community. By transporting them all into one large institution with a catchment area of almost two million people you are, in effect, unavoidably taking that chance, because it's just simply too large an area to have integrated community services and too large an institution to take care of all the community links. That is one of the dangers we are taking in joining the two hospitals into one large unit. You said that it is a very modern facility. Quite true, it's a very modern facility, very well built, et cetera.

Your government has also probably forgotten by now that three or four years ago there was a significant movement in the community to persuade the government not to build the two additional towers, which are now four; then there were two. The government said, "Oh, no, we must build them for different imperatives," so that in effect the decision was made to rebuild Queen Street, which would have been only two towers—in spite of all advice people have given to you, including mine by the way, incidentally, to which you didn't listen. You rebuilt it knowing there would be some extra beds. I'm afraid it's quite true. There was a whole movement inside the hospital and outside. We even picketed the hospital for you not to build two extra towers.



You built it. You spent the money then quite heedlessly, so you ended up with a few extra beds. The hospital has used the space very well by creating programs and by expanding. At the moment, if you insist on putting so many patients in that hospital, and you will see it when we go over there, that hospital actually cannot take what the McKinsey potential says. If you combine the two hospitals you would have to have over 800 patients in that unit.

**Hon. Mr. Timbrell:** Really what you are saying is what I was saying earlier, that the planners of a decade ago overestimated the need for psychiatric hospital beds, aren't you?

**Mr. Duksza:** Yes, but why are you compounding the error by shoving them all into one institution?

**Hon. Mr. Timbrell:** What you're saying is those planners were dead wrong and the report from McKinsey is dead right.

**Mr. Duksza:** Dead right, so why are you not listening to it?

**Hon. Mr. Timbrell:** No, you're saying this. What I am saying is that given the experience, given the experience with what the planners produced, and given what has happened in the last decade in the use of provincial psychiatric hospital beds, given the growth in community hospital units, and given the changes in chemotherapy and various other significant developments in the treatment of psychiatric illness, at this point in time for the foreseeable future, as far as inpatient needs are concerned, that facility can serve the needs.

You're talking about a facility which split off into its regional units, as opposed to how I understand the old hospital was organized, that we see it accommodating about 600 people, compared to the time when you were in the psychiatric hospital system more actively—I don't know if you're still practising or not, I haven't checked—when there were 2,000 hospital beds around Metro. I think we are really into a semantics argument. In fact, there is more of the direction of the system in the community, through the community hospitals and through community mental health groups, than ever before, and that's going to continue to grow.

**Mr. McClellan:** I'll be brief, Mr. Chairman, because I think many of the issues we're broaching tentatively in some respects today will be covered exhaustively in the testimony over the course of the hearings. I don't want to belabour these points, although they are central to the issue before us. I just think we'll have an opportunity to deal with them

on a sustained and comprehensive basis as the hearings proceed.

[5:30]

What I wanted to do very simply was to obtain a couple of pieces of information that I think would be useful, certainly to me, and hopefully to the committee, as we enter into the hearing process. The first of these has to do with the financial factor. I happen to share the Liberal health critic's view that money considerations were of paramount importance in this decision.

I would like to ask the minister, therefore, if he could tell us, since there are some time lags, I guess, in the presentation of financial data as between the estimates book and the budget that the Treasurer brought down, if you could give us what the actual expenditures were, the actual total budgetary expenditures for the Ministry of Health for the year 1978-79. I'm sure that figure must be available. That would be the total budgetary expenditure with actuals, with the supplementaries calculated in.

**Hon. Mr. Timbrell:** Yes, it's in excess of \$3.95 billion. I'll get you the exact figure. I'm not sure exactly how it broke out once we had supplementaries, because there were also offsetting savings during the year.

**Mr. McClellan:** Is it safe to use \$3.95 billion for the purposes of discussion? Okay, and that includes the \$66 million tabled as supplementary estimates in March?

**Hon. Mr. Timbrell:** Yes, there were supplementaries for some things and there were also offsetting savings during the year.

**Mr. McClellan:** Let's use the figure of \$3.95 billion—at least for the purposes of discussion. Your budget for 1979-80 is \$4,183,000,000; rounded off.

**Mr. Cooke:** The last of the big spenders.

**Hon. Mr. Timbrell:** It's almost exactly 1,000 times what my budget was when I was Minister of Energy.

**Mr. Conway:** It betrays a Prime Ministerial ambition.

**Mr. McClellan:** What is the amount of the federal contribution to the 1979-80 health budget?

**Hon. Mr. Timbrell:** The exact number you'd really have to get from the Treasurer, because it's all built in. We have tax points, we have unconditional transfers and we also have transfers to do with extended care. They're all part of the established program financing act and the formulae.

**Mr. McClellan:** I was given the figure of \$2,324,700,000 by the federal Minister of



Health and Welfare. I have trouble with these figures, they are astronomical.

I have \$2,324,700,000 as the federal contribution to Ontario's health budget of \$4,-183,000,000; that's what they say.

**Hon. Mr. Timbrell:** I understand the Treasurer was discussing this matter in the Legislature a week or two ago, and he indicated that for health and post-secondary education, roughly speaking for every dollar we get from the feds we spend a dollar in those fields. But for the exact numbers I would defer to the Treasurer. If you want, we will indicate your question to him and ask for the numbers in more precise terms.

**Mr. McClellan:** That would be helpful because, as I say, this is the figure the feds have given to our research people representing—

**Hon. Mr. Timbrell:** As the contribution to health?

**Mr. McClellan:** Yes, as your contribution to health.

**Hon. Mr. Timbrell:** I know it's nowhere near that.

**Mr. McClellan:** You say it's nowhere near that.

**Hon. Mr. Timbrell:** That would be in excess of 50 per cent of our expenditures and I know it's not.

**Mr. McClellan:** That was my concern.

**Hon. Mr. Timbrell:** They never came up to 50 per cent when we had cost sharing, so why would they do it now?

**Mr. McClellan:** Let's not pursue it here, because what I'm trying to get is an absolutely precise statement of: first, what your actuals were for 1978-79; second, what your federal contribution is for the fiscal year 1979-80.

**Hon. Mr. Timbrell:** Certainly we can get you the former; and as far as the latter is concerned, I would expect what the Treasurer and the Treasury would have would be an estimate of the effect of the formula. You said you got these from the minister?

**Mr. McClellan:** From the minister's office, yes; we phoned and asked what was the—

**Hon. Mr. Timbrell:** You had more luck getting through than most of us.

**Mr. Conway:** The coalition is already under way.

**Mr. McClellan:** Hardly; are you so pessimistic, Sean?

**Hon. Mr. Timbrell:** They forgot what happened to them the last time they went into a coalition.

**Mr. McClellan:** I'd like to know what the federal share is. I'd like to know what formula the Treasurer uses to work out the federal share.

**Hon. Mr. Timbrell:** If I remember correctly—

**Mr. McClellan:** I always thought it was a fairly—sorry?

**Hon. Mr. Timbrell:** Have you got the numbers there for MCU? Essentially what the Treasurer was saying was—

**Mr. McClellan:** For what?

**Hon. Mr. Timbrell:** MCU, Colleges and Universities.

**Mr. McClellan:** No, I'm sorry, I don't.

**Hon. Mr. Timbrell:** If you recall, when this was discussed in the Legislature—help me, Pat; a week ago, to weeks ago; whenever.

**Mr. McClellan:** Yes, I remember.

**Hon. Mr. Timbrell:** The Treasurer, who is responsible for that area, said that essentially it's a buck for a buck, in health and post-secondary education.

**Mr. McClellan:** But that's not how the formula is calculated. Ontario's share of the federal health dollar is calculated according to a formula which is based, I gather, on a per capita allocation.

**Hon. Mr. Timbrell:** It's based on tax points and certain other allocations, but I'll get you an answer from Treasury.

**Mr. McClellan:** Get me the formula, plus the amount, and then we can continue the discussion. The other thing that I'd like to ask you to provide to the committee is tabling the background policy documents that were prepared by ministry staff with respect to the decision to close the Lakeshore Psychiatric Hospital.

**Hon. Mr. Timbrell:** What I'm going to table today, and these are the kinds of arguments that are very confined too, are the following reports: For Lakeshore Psychiatric Hospital, parts one and two of a report by Mr. Manson, who is our fire consultant in the Ministry of Health institutional division, this is from May 1978; along with a report from Mr. Ross Taylor, inspector with the Etobicoke Fire Department, of March 1978 for Whitby Psychiatric Hospital; parts one and two and a review report by Mr. Hess, who is a consultant in our ministry, from November 1976 for Queen Street. We don't have any similar reports, since this facility has been undergoing rebuilding in the last 10 years, so the actual plans, the actual building speaks for itself. For Penetang we have—and

this is in answer to what you're asking me, it's also an answer to indications we've had from staff of your party prior to this.

Let's see, we have three reports—one from Mr. Stuart, the fire chief in Penetang dated January 1979, December 1976, November 1975; a report by a Mr. Quinn, a consultant in our ministry dated July 1978; and a report by another of our consultants, Mr. Hess, dated 1975.

**Mr. McClellan:** That's good, that includes a number of items we were hoping to receive. It doesn't include what I have just asked for however, that is to say the policy position papers that would have been prepared for you by your staff with a recommendation with respect to the Lakeshore Psychiatric Hospital; and included in what I would assume would be a series of documents would be your senior staff reaction to the McKinsey report as it was received by the ministry, and the recommendations that flowed out of a policy examination of the recommendations in the McKinsey report. Are you saying that none of that planning took place?

**Hon. Mr. Timbrell:** There is very little committed to paper. You've got the McKinsey report, and then you've got documents like these that speak to the condition of the buildings and the extent of the renovations required.

**Mr. Conway:** On Mr. McClellan's point, Mr. Minister, I remember in this very room about a year ago a much smaller report. I think it was the Taylor report on health care cost containment. It was the subject of a rather, I thought, extensive and fourfold ministerial response. I was quite surprised as to the degree which that document was assessed, reassessed and assessed and reassessed—I think it was four times in some of the recommendations.

**Mr. McClellan:** Five.

**Mr. Conway:** Five.

Is there no such response to a report of this magnitude with respect to what it says about institutional psychiatric care in terms of the golden horseshoe?

**Hon. Mr. Timbrell:** No, essentially, there is not that kind of—

**Mr. McClellan:** Explain to us the process of response in planning that took place within the ministry upon receipt of the McKinsey report. Surely you commissioned senior staff at the policy level to study the document and to make an assessment of it and make policy recommendations to you. Isn't that the

normal way you would deal with a major consultant's study?

**Hon. Mr. Timbrell:** First of all, the officers of senior staff were going over the report.

**Mr. McClellan:** Who were they who went over the report?

**Hon. Mr. Timbrell:** The psychiatric hospitals branch where Mr. Jappy is.

**Mr. McClellan:** So it would be a group under Mr. Jappy? Is that correct?

**Hon. Mr. Timbrell:** Mr. Jappy is a director of the branch and he has very few people in the branch office as such. Mainly, his branch consists of the people who are responsible for administering the individual psychiatric hospitals.

**Mr. McClellan:** Who within the branch? Was there a policy group or a senior management group? Was it Mr. Jappy himself who did an assessment and reported to you?

**Hon. Mr. Timbrell:** Essentially we discussed the implications of this at a series of discussions, either at the management level or with me. This went on over a number of months.

**Mr. McClellan:** Nothing was committed to writing, you say?

**Hon. Mr. Timbrell:** Very little.

**Mr. McClellan:** All right.

**Hon. Mr. Timbrell:** We didn't do the kind of analysis, and we don't do it for every report, that was done for—we didn't do it for the select committee.

**Mr. Conway:** One almost gets the impression you stopped doing that as of about April 25, 1978.

**Hon. Mr. Timbrell:** No.

**Mr. Conway:** That's just a cynical observation.

**Hon. Mr. Timbrell:** I detect the cynicism.

**Mr. Conway:** And I can't altogether blame you.

**Mr. McClellan:** When then was the decision taken to close Lakeshore?

**Hon. Mr. Timbrell:** The decision was taken late in 1978.

**Mr. McClellan:** Late in 1978?

**Hon. Mr. Timbrell:** By cabinet.

**Mr. McClellan:** You went to cabinet with a proposal.

**Mr. Dukszta:** No, that's precisely the question. Did you go to cabinet with the proposal to close Lakeshore?

**Hon. Mr. Timbrell:** Yes.

**Mr. McClellan:** Yes, you did, and cabinet approved? Yes, I assumed that was the



normal sequence. What I'm simply trying to find out is when you made the decision within the Ministry of Health, and on the basis of what ministerial studies I would like the committee to have the benefit of the same kind of staff analysis that you, as minister, would inevitably have had in order to take as serious a decision as that.

[5:45]

**Hon. Mr. Timbrell:** I can't recall an exact date, to be sure, but the discussions about the McKinsey report and the alternatives led me to put the matter forward as a possibility some time ago late last spring.

**Mr. McClellan:** Within the ministry?

**Hon. Mr. Timbrell:** Discussion within the ministry, and in the early stages of discussing our needs for 1979-80. I'll go back and check the documentation, such as there is, but, essentially, the ultimate decisions were based on very lengthy discussions batting all the alternatives around, and how patients could be looked after and so forth.

**Mr. McClellan:** It was all done on the basis of chit chat?

**Hon. Mr. Timbrell:** "Chit chat" is hardly the right expression.

**Mr. McClellan:** The normal process, I would expect, is that you would have your staff do a serious policy analysis which would lay out for you a number of options and the consequences of each of those options. That's the kind of information I suspect you, as minister, would have received from your staff as the basis for an intelligent, informed decision, and I am asking if you would provide those documents to the committee.

**Hon. Mr. Timbrell:** As I said, I will examine that.

**Mr. McClellan:** I don't believe that they don't exist, quite frankly.

**Hon. Mr. Timbrell:** There are a very few other than cabinet documents and cabinet submissions, and you know where we stand on cabinet submissions.

**Mr. McClellan:** The decision might have been taken, but on the point that you made, your submission to cabinet, I want to know what was the information base for you, within the ministry, to take the decision you did.

**Hon. Mr. Timbrell:** Essentially you've got it.

**Mr. McClellan:** These three documents?

**Hon. Mr. Timbrell:** All of the factors that we have discussed today and in the months leading up to today. There are certain basic things: you have the McKinsey report.

**Mr. McClellan:** Which does not support your course of action.

**Hon. Mr. Timbrell:** I acknowledged that from the beginning and I ask you to acknowledge that there are certain facts that weren't included there. Then, there are these reports, and the practical considerations of whether Queen Street and Hamilton could accommodate the inpatient needs.

**Mr. McClellan:** Is that in these documents? These are fire inspection documents.

**Hon. Mr. Timbrell:** Is what in these documents? Yes, these are fire inspection documents.

**Mr. R. F. Johnston:** The ability of Queen Street to handle it.

**Hon. Mr. Timbrell:** That is, essentially, information that came to me from people like Mr. Jappy. Anyway, I will examine what is available and try to help you out.

**Mr. McClellan:** Surely, you must have had your staff sit down and cost out a series of options. Or did they say, "Golly, this is going to be too damn expensive"?

**Hon. Mr. Timbrell:** We already had an estimate of the cost of rebuilding from McKinsey. I think their estimate was 22 million; I've heard other estimates more recently, again verbally, approaching \$30 million, but, McKinsey has used the figure of \$22 million, so it's essentially there.

**Mr. McClellan:** Essentially where? In this stuff?

**Hon. Mr. Timbrell:** In McKinsey and in the fire reports, and there is also an earlier report that I can recall, prepared by MGS in 1976 or 1977.

**Mr. McClellan:** That is on the Lakeshore?

**Hon. Mr. Timbrell:** Yes.

**Mr. McClellan:** That was one of the things I was going to come to.

**Hon. Mr. Timbrell:** There is an earlier one, but I'll be glad to get you that.

**Mr. McClellan:** What I really want—and you understand, I'm sure, with absolute clarity, what I want—are the position papers that were presented to you by your senior officials upon which you based the decision to close Lakeshore.

**Hon. Mr. Timbrell:** Essentially very little was committed to writing. It consisted of direct discussion of an evaluation of McKinsey and then a determination to make a recommendation to cabinet.

**Mr. McClellan:** Is this within a group of the ministry that you had these discussions?

**Hon. Mr. Timbrell:** Yes, my senior—



**Mr. McClellan:** Or at lunch time?

**Hon. Mr. Timbrell:** With senior advisers at meetings called to discuss the matter in my office.

**Mr. Conway:** Who doubts but what this exchange could have been anything but a humble Minister of Health going to a Treasurer asking for \$50 million to build two new hospitals and being sternly told, "You will have one and you make the choice." Surely that's what we're dealing with. As my friend from Lakeshore would say, it is self-evident reality.

**Hon. Mr. Timbrell:** Political fiction will always make good reading.

**Mr. Conway:** I saw it as the art of the possible. I don't even expect it to have reached that level of analytical input.

**Mr. McClellan:** Are you saying there was no costing of the kinds of renovation that would be required to bring Lakeshore up to an adequate standard, aside from McKinsey?

**Hon. Mr. Timbrell:** It's in McKinsey; we took that as a current estimate—

**Mr. McClellan:** So the ministry did know—

**Mr. Lawlor:** That's not accurate. If I might interject just for a moment. Let's take a look at what McKinsey does say at (a)2—it's very short: "Several approaches can be taken to upgrading facilities at Lakeshore and Whitby. Existing buildings can be torn down and replaced with new construction. Alternatively, facilities could be renovated and refurbished to meet most pressing improvement needs." It doesn't have to be holus-bolus.

The final sentence: "In between are a range of possibilities involving partial rebuilding and partial renovation."

**Mr. McClellan:** The other thing that is incomprehensible to me, in the light of what the minister is saying, is that clearly there was absolutely no planning for what to do with the outpatient facilities that were going to be terminated. Otherwise you would have other documents presented to you at the time you were having discussions with respect to the disposition of Lakeshore which set out with some precision what your contingency plans were for the myriad of outpatient services which were jeopardized.

**Hon. Mr. Timbrell:** There is a lot of documentation about the state of Lakeshore; we have given you the most recent fire materials, for instance. There is an earlier MGS study that Mr. Jappy tells me about, and I will be able to get it for you. But you are going to have to reproduce it. My budget won't take it. It is 120 pages.

**Mr. McClellan:** Our committee is quite capable of receiving and reproducing it.

**Hon. Mr. Timbrell:** Apparently, just to bring it up to code for energy matters alone was about \$9 million, Mr. Jappy recalls. These are the kind of things. There are all kinds of things.

**Mr. McClellan:** A minute ago there was very little.

**Hon. Mr. Timbrell:** I am talking about the kinds of things like these reports that you have already got—

**Mr. R. F. Johnston:** When there are so many, have you never brought them all together in one policy paper by one of your senior people as advice to you? Instead you sat around and talked about this paper here and that paper there?

**Hon. Mr. Timbrell:** No, we talked about the report in its entirety with regard to the various aspects.

**Mr. McClellan:** Did you develop a comprehensive plan for the orderly provision for the outpatient services program, the total package of programs, at Lakeshore or not? If you did, please provide it to us.

**Hon. Mr. Timbrell:** We did. What we did was—

**Mr. McClellan:** I don't understand why we are having so much difficulty here.

**Hon. Mr. Timbrell:** What we did was to establish the—

**Mr. McClellan:** I don't understand. Do you understand? I am not trying to be smart about it; I am trying to get some background information.

**Mr. Gregory:** Why don't you stop talking and listen to what the minister is saying?

**Hon. Mr. Timbrell:** What we did, and we discussed this earlier at some length, was to establish the group under Dr. Lynes to receive submissions on the outpatient program. Since then, in order to effect an orderly transfer of the inpatients there has also been a group overseeing that activity, so that it would be an orderly process.

Sure, we could have sat down and said, "All right, when we make the announcement it will be a total package and we will announce all the outpatient stuff at the same time," and go out and sign leases or whatever. We could have made the decisions ourselves about what services should be expanded where. Instead, what we decided to do was to invite the submissions which have been received by Dr. Lynes' group which closed off Friday night, the 20th, and which are being assessed right now.

That is the plan we put into place to cover the outpatient and inpatient programs, once it was determined from the advice given to me by my staff that Queen Street and Hamilton could in fact more than amply accommodate the inpatient needs.

**Mr. McClellan:** I do not understand why this is becoming such a convoluted and difficult discussion.

**Hon. Mr. Timbrell:** Neither do I.

**Mr. McClellan:** All I am asking to receive are the policy documents that would have set out your course of action, the options open to you, and the information base upon which you made the decision.

**Hon. Mr. Timbrell:** I will see what else there is but essentially, when you look at McKinsey and you look at fire reports and you look at the MGS report and you look at the services and facilities available at Queen Street and Hamilton, you have the information you need on which to decide whether it is a go or no go and then to make a recommendation. Have a look at this; I will get you the MGS report as well.

**Mr. McClellan:** Curious operation.

**Mr. R. F. Johnston:** I am a little concerned to think the community service side of things was not taken into account as a larger factor before making a decision. Therefore, you had some sort of reports in before about the possibility of community support to handle the needs. It should have been one of the major factors taken into account.

One of your statements at the beginning was that unlike California, Ontario has looked after the people it has released in the last 10 or 15 years from psychiatric hospitals. As somebody who has worked in programs through your ministry to do with helping people in the community, I feel that has not been the case, especially not in the first five to six years of that period. Of late, even though there are projects—and you listed a number of the 55 or 69 projects that are operated through your ministry—in my view there is very little co-ordination. The evaluation process for those projects, in my view, as far as the systematic ability to maintain somebody in the community is concerned is suspect; it does not look at their total needs in terms of co-ordination with psychiatric hospitals.

I am interested in the fact the slides you showed I think were patently exaggerated. I think it would have been far better if you had shown the film—I forget the name of it now—about the assessment unit you have that was started in Lakeshore. That has a wonderful combination of shots from Queen

Street and Lakeshore and I think it even has Whitby in it. It shows them all as being relatively useful, especially the service that was developed in cooperation with the DARE project, which is a very good one.

My involvement has been primarily with Whitby as an institution. In some ways, I would see you penalizing the hospital which has taken more action in terms of community support than any of the hospitals I know in the province. You would be giving money to one of the ones which has done the least with community support and its co-ordination. I think that is unfortunate. Spending \$27 million or whatever it is going to cost to upgrade Whitby and keep it at the same number of beds is not the priority that should have been chosen if you are to take an either/or situation. I think that naturally shows you did not take the quality of community support into consideration in advance—the community support work which has already been developed by Lakeshore which also has a very strong base of having inpatient service there as well. Providing good community support, in my view, is a very crucial thing.

**Hon. Mr. Timbrell:** Let me respond because there are only a couple of minutes left. In fact, we did take into consideration the fact that kind of network has been developed, to build on in the area. There are other practical considerations. Coming back to the question of capital being available, there was enough for one or the other, but not two. You know the size of Whitby's catchment area.

**Mr. R. F. Johnston:** Exactly.

**Hon. Mr. Timbrell:** It extends right out to the boundary of Peterborough and Hastings counties and up into Victoria and Haliburton counties.

**Mr. R. F. Johnston:** A lot of natural links, I would say, especially West York. What is the connection there with Whitby?

**Hon. Mr. Timbrell:** I guess because of the type of community served, compared to Durham, and essentially as compared to Metro. In fact, that was taken into consideration.

**Mr. R. F. Johnston:** But again, nothing was written down?

**Hon. Mr. Timbrell:** I will check the records on that. The information on which you need to make a decision is all here in these kinds of reports, and in the MGS report which I will get for you which details the conditions of the facility. There is the accreditation report, too, which we already have, and which I think you have seen. All of the information is there.



**Mr. R. F. Johnston:** I am not sure it is. I think the decision was made to close down an institution with great roots in its community and to keep one which I would suggest maybe has not done as well, without looking at—

**Hon. Mr. Timbrell:** I don't think you are going to suggest that we not rebuild Whitby?

**Mr. R. F. Johnston:** Certainly not, no. That's not what I am saying at all.

**Mr. Duksza:** That's not what he is saying at all.

**Mr. R. F. Johnston:** Without looking at things like developing a real psycho-geriatric experiment out there—using that facility for that kind of specialized use—

**Hon. Mr. Timbrell:** Where?

**Mr. R. F. Johnston:** Lakeshore as an example. Why not? You talk about lateral links. You have this dialysis group which is now going to have to go all the way from—I gather some people from as far as Hamilton will have to go take the dialysis treatment in Whitby. That to me has no natural link with that at all.

**Hon. Mr. Timbrell:** We will hold off the final decision on that until we finalize everything on the outpatient services.

**Mr. R. F. Johnston:** I won't go on then.

**Mr. Conway:** A brief supplementary to Mr. McClellan's point. I want to just recommend this for the minister's attention, because I think the members sitting in this committee who have to make some kind of an assessment about the decision, and whatever, have two basic things to consider. First is the capacity of the facilities at Queen Street and Hamilton to accept now and in the future the patient load in the institutional setting. That's something we will hear a lot about within the next few days. But secondly there is going to be a debate and presumably a fair bit of evidence dealing with the capacity of the catchment area to deal in one way or another with those community services that may or may not be lost as a result of the closure of Lakeshore.

I want to really underscore Mr. McClellan's point. It may be that we need Dr. Lynes here to give us some testimony at a later date. Some time in the not-too-distant future I want to be absolutely assured from the min-

istry's point of view there is some kind of systematic plan for the provision of, and the continuation of, those community services Mr. McClellan was drawing attention to.

**Hon. Mr. Timbrell:** Mr. Conway, if we were meeting three to four weeks from now, all of the assessment work Dr. Lynes has to do of the submissions received on Friday would have been completed—

Interjection.

**Hon. Mr. Timbrell:** Hold it. This is after the community involvement, which is what you are telling me there should be, in making the submissions.

**Mr. Duksza:** Before the decisions, not after. You don't close the stable after the horse has fled.

**Hon. Mr. Timbrell:** I think there are some things you have to accept when you are in a position such as I have. You have to make a basic decision and go with it. Then there is the followup, and in this case asking for the receipt, assessment and approval of submissions for expanded outpatient services, which should involve, and in this case has involved, the public extensively.

**Mr. Chairman:** We are past the adjournment hour, Mr. Lawlor. We will be here at the same stand tomorrow.

**Mr. Lawlor:** Is it the intention that the minister return tomorrow? My own feeling is that we have a fairly heavy schedule of witnesses. I can abide the reappearance of the minister while we explore other areas.

**Mr. Chairman:** It's up to the committee. I should tell you we have 10 people scheduled to appear, if the committee members wish to question them. All of those people are associated in some capacity with the Lakeshore hospital operation.

**Mr. Lawlor:** The steering committee will set it up and let the minister know.

Interjection.

**Mr. Conway:** The minister has kindly indicated he would return at a later date. I think that is certainly agreeable to us.

**Mr. Lawlor:** That is agreeable to me.

**Mr. Chairman:** Fine, thank you. The committee is adjourned.

The committee adjourned at 6:04 p.m.



### SPEAKERS IN THIS ISSUE

---

Breaugh, M. (Oshawa NDP)  
Conway, S. (Renfrew North L)  
Cooke, D. (Windsor-Riverside NDP)  
Dukszta, J. (Parkdale NDP)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Gregory, M. E. C. (Mississauga East PC)  
Johnston, R. F. (Scarborough West NDP)  
Lawlor, P. D. (Lakeshore NDP)  
McClellan, R. (Bellwoods NDP)  
Timbrell, Hon. D. R.; Minister of Health (Don Mills PC)

**From the Ministry of Health:**

Jappy, W. C., Director, Psychiatric Hospitals Branch









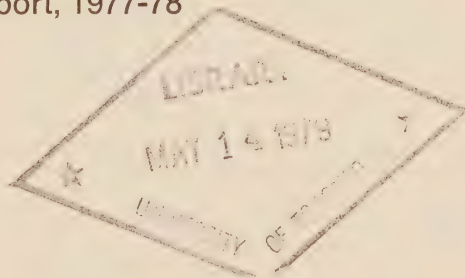
No. S-6

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Tuesday, April 24, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

## LEGISLATURE OF ONTARIO

---

TUESDAY, APRIL 24, 1979

The committee met at 3:20 p.m.

### MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Chairman:** I see a quorum. I think we'll commence.

Ladies and gentlemen, this afternoon we have a number of people with us. Perhaps I should read off the list of those people who are here and who, I understand, do not have any prepared statements but are available for questioning as far as the members of the committee are concerned: Mr. McMullen, administrator of Lakeshore Psychiatric Hospital; Dr. Bond, medical director of Lakeshore Psychiatric Hospital; Dr. Maharaj, director of the alcohol services unit; Dr. Frank, of the special observation unit at the psychiatric hospital; Mr. Suttis, maintenance department head; Mr. Emile Barnes, who is responsible for fire safety at the hospital; Celia Royce, president of Lakeshore Volunteers Association; Mr. J. R. Bateman, Ontario fire marshal; Inspector Ross Taylor, Etobicoke Fire Department, and Joan Best, Community Resources Consultants.

With the committee's concurrence, perhaps we could start with Mr. McMullen. Mr. McMullen, there may be some members who would like to ask you questions. Would you sit at the table and make yourself comfortable? This isn't an inquisition, Mr. McMullen. The members of the committee are interested in certain facts and background with respect to the hospital, so kindly relax. If you want a drink of water, I am sure one of the members would be glad to provide it for you.

**Mr. Conway:** Mr. McMullen, as administrator of Lakeshore Psychiatric Hospital, you are a provincial civil servant. Am I correct?

**Mr. McMullen:** That is correct.

**Mr. Conway:** You have been administrator at Lakeshore for how long?

**Mr. McMullen:** About a year now.

**Mr. Conway:** Prior to being administrator at Lakeshore Psychiatric, where and in what capacity did you serve?

**Mr. McMullen:** I was the assistant administrator at Lakeshore for six years.

**Mr. Conway:** How long has your experience with Lakeshore been?

**Mr. McMullen:** Seven years.

**Mr. Conway:** Can you indicate to us exactly at this time the state of the closure of Lakeshore? I am interested particularly to know where we stand on this day with respect to what has occurred at Lakeshore, and how much of the transfer or how much of the shutdown has proceeded?

**Mr. McMullen:** In terms of patients, we have transferred those patients from North York and Halton and York region. We have also transferred those geriatric patients from Lakeshore to Queen Street. In terms of numbers, I'll have to ballpark it. Our census, prior to the closure announcement, was running around 300 inpatients. We are down to about 200 now, so about 100 patients have been transferred to date.

**Mr. Conway:** It's my understanding, Mr. McMullen, that Lakeshore has for some time served as an overflow centre for Penetang. Am I correct in that?

**Mr. McMullen:** No, that is not quite accurate.

**Mr. Conway:** What is an accurate description of the relationship between Lakeshore and Penetang?

**Mr. McMullen:** I think you are talking about the patients who are Lieutenant Governor's warrants.

**Mr. Conway:** Yes, Lieutenant Governor's warrants.

**Mr. McMullen:** Each regional hospital, Lakeshore being one of them, has some responsibility in accepting those patients who are on the warrant of a Lieutenant Governor when they have achieved a point where it is in their interest, for rehabilitative purposes, to get closer to the community. When this is indicated in Lakeshore and Penetang, then the patients come to Lakeshore or any of the other regional psychiatric facilities.

**Mr. Conway:** In your time at Lakeshore, the seven years, could you give us a ballpark figure of how many such Lieutenant Governor's warrant patients there would be at any given time, on average, at Lakeshore?

**Mr. McMullen:** Right off the top of my head, 17.

**Mr. Conway:** There would be 17 on a traditional base of 250 to 300?



**Mr. McMullen:** Yes.

**Mr. Conway:** Does the treatment required for such a patient differ significantly from the other patients at Lakeshore? I am particularly interested from the point of view of the facility. Does a facility receiving those kinds of special Lieutenant Governor's warrant cases require certain plant readjustments for their treatment and rehabilitation?

**Mr. McMullen:** That is difficult to answer because I think you are really asking for a professional opinion. I speak to the question from the administrative point of view, and I think the LGWs are probably easier to deal with administratively than other patients.

**Mr. Lawlor:** With respect, you should ask that of Dr. Frank.

**Mr. Conway:** I will be quite happy to do that, Mr. Lawlor. I was wondering what Mr. McMullen's comment from the point of view of administering that general facility would be.

In so far as the catchment area is concerned, your involvement with Lakeshore has, as you indicated, been over the course of seven years, and we have been impressed by a great amount of public comment and some evidence that the facility has been under-utilized in so far as its bed capacity is concerned for a number of months and years now. Is that the experience you have had in your time there? Have there been any contributing causes that have not been brought to light that you can comment upon in that connection?

[3:30]

**Mr. McMullen:** Were you suggesting the facilities of Lakeshore were under-utilized?

**Mr. Conway:** Yes. The popular perception is of a large provincial psychiatric hospital that is and has been for some time under-utilized in so far as the patient load is concerned.

**Mr. McMullen:** I don't really think it is under-utilized. If you look at the history of the facility, you will probably find there were as many as 1,100 beds there some 10 or 15 years ago. Today we find our rated capacity is 409 and so you probably would automatically say it was under-utilized. However, with the different modes and things that go on, those under-used spaces, or spaces you would think would be under-used, are now used as activity areas and that type of thing.

**Mr. Conway:** Is it your experience in your time in the field and at Lakeshore for seven years that rating capacities have as much to do with budgetary considerations as they do with the provision of good psy-

chiatric care in an institutional setting? I am thinking specifically of a range of bed capacity that you indicated was as high as 1,100 and now has a rating of 409. If I understood you correctly, at one time in your time at Lakeshore there was a rating capacity of 1,100? Did I understand you correctly?

**Mr. McMullen:** On that order, yes.

**Mr. Conway:** On that order. It's now down to 409. To the average lay person, that is a substantial range. I am wondering whether or not your experience at Lakeshore and any other facility in the psychiatric field leads you to believe that rating capacity has as much to do with budgetary considerations as it does to health care planning?

**Mr. McMullen:** No, I don't think so. To achieve the smaller census requires more human resource. If you are going to have adequate human resource, then that's where your budget is used up.

**Mr. Conway:** I am interested to pursue this a little further. In your time at Lakeshore, was there ever an actual patient load in the order of 900 to 1,100?

**Mr. McMullen:** No.

**Mr. Conway:** There never was?

**Mr. McMullen:** No.

**Mr. Conway:** But there was a rating capacity in that order. Correct?

**Mr. McMullen:** That's correct.

**Mr. Conway:** What was the maximum patient load in your time at Lakeshore?

**Mr. McMullen:** It was more than the 409 figure that I gave you, but I'm afraid my memory fails me.

**Mr. Conway:** Have you served in other institutional psychiatric settings in other such hospitals as Lakeshore?

**Mr. McMullen:** No, I have not.

**Mr. Conway:** Your experience prior to going to Lakeshore was what?

**Mr. McMullen:** In the mental health branch.

**Mr. Duksza:** I thought you were in Owen Sound for a short time.

**Mr. McMullen:** Yes, that's quite so. I was.

**Mr. Duksza:** You helped to close that, didn't you?

**Mr. McMullen:** I helped to close that.

**Mr. Duksza:** I just wasn't clear when I heard you were not in another institution.

**Mr. McMullen:** I thought he was speaking of a lead-up towards Lakeshore, and I wasn't.

**Mr. Conway:** When were you in Owen Sound?

**Mr. McMullen:** About a year ago.

**Mr. Conway:** Then I move to ask the obvious question, as a bit of a pattern appears here. There may be some popular perception that you may be the designated hitter, as it were, in the ministry's lineup to close down—

**Mr. McMullen:** Please don't label me with that.

**Mr. Conway:** But it is true that you had in the last year and a half the happy or unhappy facility of being associated with two closures.

**Mr. McMullen:** Not really. McKinnon Phillips Hospital in Owen Sound really merged with the General and Marine. It is not quite the same as a closure.

**Mr. Conway:** How would you describe for the committee the relationship you as administrator of Lakeshore Psychiatric have enjoyed with the area in which the facility is located—the general catchment area? Has it been a very good one, an indifferent one or a very bad one?

**Mr. McMullen:** I would say it was a very good relationship.

**Mr. Conway:** It is, as I understand it, among the best because of the long historical experience of that facility being there.

**Mr. McMullen:** Yes.

**Mr. Conway:** One of the points that's often made—the minister has made it on one or two occasions in the House and it has been repeated elsewhere—is that among the principal reasons for closing this facility is that it is a firetrap in some aspects that has led to the death of at least one patient. Can you comment on that from your own views as an administrator of the facility and, in particular, with the death of the one patient some months ago?

**Mr. McMullen:** It is my opinion the fire safety procedures at Lakeshore were second to none. I think they were excellent. We had an extremely conscientious hospital fire marshal and to the best of my knowledge we had the best of equipment. We had smoke detectors; we had alarm systems. They were all hooked into the local firehall. We ran drills periodically—probably more frequently than most facilities. I really think Lakeshore was as safe as any hospital in Toronto.

**Mr. Conway:** Can you deal with the one fatality that has occurred in the recent past and about which much has been made?

**Mr. McMullen:** My opinion is that if you're dealing with a pyromaniac an accident like that could happen almost anywhere.

**Mr. Conway:** And the principal point to be made in this connection is just that—it was not a structural deficiency in the building so much as the human factor?

**Mr. McMullen:** You're correct.

**Mr. Conway:** That is a very important point since the contrary impression, it seems to me, has been left by others. In your time at Lakeshore in the past seven years much has been done in so far as renovation is concerned. In one instance, I believe, the vocational training centre which was built about 1973—I recall a cornerstone being laid about that time—

**Mr. McMullen:** Yes.

**Mr. Conway:** —at, I suspect, not inconsiderable cost—could you indicate, taking that as a beginning point, how much money has been spent in renovating the Lakeshore facility? Could you give us any ballpark figure, perhaps indicating in general where the renovations have occurred?

**Mr. McMullen:** I would hesitate to do it because my figures are not really accurate. I know that Mr. Suttis is here today and he can probably give you accurate figures in that regard.

**Mr. Conway:** Could you characterize the nature of that? Was it \$100, \$1,000, \$1 million?

**Mr. McMullen:** The trades building, as we call it, I believe was on the order of \$3 million. More recently we installed part of a new electrical system that I understand was worth about \$250,000. Many of the cottages at the hospital were reroofed last summer at some considerable expense. Once again, I can't tell you the figure.

**Mr. Conway:** When and how, Mr. McMullen, did you personally hear of the government's intention to close Lakeshore?

**Mr. McMullen:** January 22.

**Mr. Conway:** You were given no prior notice?

**Mr. McMullen:** No.

**Mr. Conway:** Have you been given any indication as to where you personally will be reassigned if at all?

**Mr. McMullen:** No; I've been told that my position is protected.

**Mr. Conway:** Nothing more than that?

**Mr. McMullen:** No.

**Mr. Conway:** So that fully three months after the government's announced intention, so illustrious a personality as the administrator has been told no more than that his position will be protected. You have no more definite indication than that from government as to what your future is? No inkling at all?



**Mr. McMullen:** There is some indication there may be a position opened in Queen Street—999, 1001, whatever.

**Mr. Conway:** That, for the moment, Mr. Chairman, exhausts my questions.

**Mr. Lawlor:** Mr. McMullen you're perhaps a little the opposite of Winston Churchill who did not wish to preside over the dissolution of the British Empire. However, in your role at Owen Sound and again, unfortunately, your role at Lakeshore, that is the position that you're at present occupying isn't it?

**Mr. McMullen:** That's quite true.

**Mr. Lawlor:** Have you no more definite commitment with respect to an assistantship or some major role at Queen Street than you're able to indicate at the moment? I've heard rumours you were being appointed.

**Mr. McMullen:** Yes but nothing is confirmed yet. There is some discussion about a change in the organization at Queen Street wherein there would be two assistant administrators. I may be one.

**Mr. Lawlor:** You look forward to that? That's a silly question. No man could possibly.

What is your relationship to the McKinsey report? Did you have any input?

**Mr. McMullen:** I was present during that period of time. I attended the various meetings that took place between the consultants and the ministry.

**Mr. Lawlor:** This was constant and on-going conversation?

**Mr. McMullen:** Not entirely. There were periodic meetings once a month.

**Mr. Lawlor:** Once a month for how long a period of time?

**Mr. McMullen:** Six to eight months, I reckon.

**Mr. Lawlor:** Without going into specifics, do you agree with the general tenor, direction and comments—leaving out capitalization, leaving out \$50 million for a moment? Do you agree with the tenor of that report?

**Mr. McMullen:** I did.

**Mr. Lawlor:** One other question: the hospital was given some kind of award not long ago. Can you tell the committee about that?

**Mr. McMullen:** Is that accreditation you are referring to?

**Mr. Lawlor:** I think so.

**Mr. McMullen:** Yes, the hospital was accredited for another three years.

**Mr. Lawlor:** What does that mean?

**Mr. McMullen:** Three years is the maximum period of time that any hospital will be accredited. You may be accredited for fewer

years or you may be provisionally accredited. We received full accreditation for the full period.

**Mr. Lawlor:** And that's somewhat unique, I understand, with Lakeshore; is that so? It's not quite the same accreditation as elsewhere?

**Mr. McMullen:** I think the only thing that really makes it unique with Lakeshore is that Lakeshore was the first psychiatric facility in the country to receive accreditation.

**Mr. Lawlor:** Could you explain a little to the committee what accreditation means?

**Mr. McMullen:** It means standard of care. It means excellence in programming. It means fire safety. It means patient safety—all of those things.

**Mr. Lawlor:** For instance, has Whitby got the same status in accreditation?

**Mr. McMullen:** I'm not sure.

**Mr. Lawlor:** Queen Street?

**Mr. McMullen:** I believe Queen Street has accreditation.

**Mr. Lawlor:** Could you give me any indication as to when that was forthcoming to Queen Street?

**Mr. McMullen:** I couldn't tell you, I'm sorry.

**Mr. Lawlor:** Those are all the questions I have at the moment, thank you, Mr. Chairman.

**Mr. Pope:** Mr. McMullen, you indicated for LGWs there were 17?

**Mr. McMullen:** That is correct.

**Mr. Pope:** You gave a very specific number. Is that an average over a period of years, or how did you arrive at that number?

**Mr. McMullen:** No, that's not an average over a period of years. That is those patients on a warrant of the Lieutenant Governor for whom we have been made responsible. I don't think the number of LGW's has ever exceeded that number.

[3:45]

**Mr. Pope:** Then it could have been less at various times but it never exceeded 17.

**Mr. McMullen:** Correct.

**Mr. Pope:** Over the period of your involvement at Lakeshore, would you have any idea on average of how many LGWs you would have at any time?

**Mr. McMullen:** Probably about a dozen.

**Mr. Pope:** Up to what year was the rated capacity 1,100?

**Mr. McMullen:** No, no; you mistake me. I didn't say the rated capacity. I said we had



as many as up to 1,100 patients in the hospital many years ago.

**Mr. Pope:** Would that be when you were first involved?

**Mr. McMullen:** No, not at all.

**Mr. Pope:** Was it before then?

**Mr. McMullen:** Quite.

**Mr. Pope:** When you were first involved with the administration at Lakeshore, how many patients would you have had then?

**Mr. McMullen:** I would think we probably had on the order of about 400, but I would like to have an opportunity to confirm that.

**Mr. Pope:** Could you for us?

**Mr. McMullen:** I'll try.

**Mr. Pope:** Thanks. Was there any change in the rated capacity during the years you were involved with the administration of Lakeshore?

**Mr. McMullen:** Yes, I think it dropped from 500-and-something to 409.

**Mr. Pope:** Okay. And that's where it was up to the present day; at 409.

**Mr. McMullen:** That's correct.

**Mr. Pope:** Was there any reason given for that drop in the rated capacity?

**Mr. McMullen:** If there was, I don't recall what it was.

**Mr. Pope:** Could the rated capacity have been lowered because of the associated services that required space?

**Mr. McMullen:** No, I think not. That would probably be a situation of setting up beds or taking beds down to make space, depending on your occupancy and demand for beds.

**Mr. Pope:** So if there was no demand for the beds, you would then take them down and convert the space to other uses.

**Mr. Mullen:** Yes.

**Mr. Pope:** Did you ever receive any complaints from staff regarding the facilities at Lakeshore—that they could have been better or there were some specific problems?

**Mr. McMullen:** Yes, of course. As everybody knows, Lakeshore is an old hospital and it lacks in privacy and these sorts of things. I think it probably lacked in personal comforts. The director of nursing and her staff were constantly upgrading this through the purchase of new and more modern beds, furniture and chairs. We had a decorating committee that tried to colour scheme the place to make it look more comfortable. We broadloomed various areas to make it more homey and warm. But there were definitely staff complaints, mainly nursing complaints.

**Mr. Pope:** How many complaints would you have in the course of a year?

**Mr. McMullen:** I don't think you could ever number them. These were sort of ongoing comments that you would get during management committee meetings and things like that.

**Mr. Pope:** From your recollection, how much of your yearly budget in the time you were associated with Lakeshore would be spent on these kinds of repairs, if you will, or replacements or improvements?

**Mr. McMullen:** It seems to me that I recollect spending \$50,000 on beds one year. I can't give you dollar figures. We spent a considerable amount of money on mattresses. We were furnished with foam rubber mattresses at one point, and they proved to be a bit of a fire hazard in that they gave off toxic smoke. Those were all changed. Furniture and carpeting in a year probably accounted for another \$20,000. But this was ongoing. You asked me a difficult question. I'd have to ask my financial officer to come up with the figures.

**Mr. Pope:** Right. Did you receive many comments from patients concerning the lack of privacy or the state of the facilities?

**Mr. McMullen:** Peculiarly enough, I didn't; not from the patients. I think the patients liked the old place, really. What they liked about it I don't know. Perhaps it had a homey atmosphere or a certain warmth, but they liked it.

**Mr. Pope:** In your earlier discussions, I think with Mr. Conway, you mentioned some electrical work and some roofing that had to be done. Were there any specific complaints you had with regard to the physical facility?

**Mr. McMullen:** As far as the electrical work was concerned we just did not have the capacity to drive new equipment. We couldn't upgrade our floor-cleaning equipment or air-condition the geriatric ward because we didn't have the power. Those were the sort of things we were concerned about, so that work or a phase of it was completed.

**Mr. Pope:** Were there any other complaints that you had concerning the physical facility?

**Mr. Mullen:** Not that immediately come to mind.

**Mr. Pope:** Did you have any money budgeted this year in capital improvements?

**Mr. McMullen:** No, I have no budget this year.

**Mr. Pope:** Did you have plans this year for any capital improvements?

**Mr. McMullen:** I would have had plans.

**Mr. Pope:** And what would those improvements have consisted of?

**Mr. McMullen:** More patient privacy, changing various wards around to make them more efficient, that sort of thing.

**Mr. Pope:** In what way would you make them more efficient?

**Mr. McMullen:** You have to remember that each ward or each cottage exists on three floors and it's a difficult situation to man them properly in many instances. What we were trying to do was centralize doctors' office, psychologists' offices and things like that so that the areas that had previously been given up to that use could be utilized as bed space or activity space for the patients.

**Mr. Pope:** Had you previously attempted to get these improvements included in your budget in previous years?

**Mr. McMullen:** That's correct.

**Mr. Pope:** Then you must have had an estimate as to the amount of money that would be involved in these kinds of capital projects?

**Mr. McMullen:** So many of these projects weren't capital projects. We had an excellent maintenance staff in the hospital and much of the work we did ourselves. As the shape of the program would change, so would we shape the cottage to meet the needs of the program. To come along and say we had capital projects to look after this is not quite correct.

**Mr. Pope:** Was there any significant change in your maintenance budget to accommodate your plans as a result of some of the problems?

**Mr. McMullen:** No, we were able to carry on.

**Mr. Pope:** So you had no estimate then of cost of materials or number of manhours that would have to be allocated to do this kind of work?

**Mr. McMullen:** No, I hadn't.

**Mr. Pope:** When your specific plans, which you indicate you had attempted to have put in your budget in previous years, were turned down, were you given any reduction in your budget as a result of the ministry turning down those plans?

**Mr. McMullen:** No, we didn't have any reduction.

**Mr. Pope:** You just didn't proceed with these plans, but you did include them in your budget?

**Mr. McMullen:** That's correct.

**Mr. Pope:** Did you receive any estimates from any source as to what costs you were looking at?

**Mr. McMullen:** I think perhaps you're getting back to McKinsey, the role study. I think a lot of the emphasis on our own maintenance perhaps dropped off when the recommendation in the role study indicated a new facility should be built, because at one point that possibility was quite rosy.

**Mr. Pope:** And for that reason you never proceeded with any plans.

**Mr. McMullen:** Yes.

**Mr. Pope:** You had earlier indicated that the main problems as you saw them were the electrical problems and you said a phase of that improvement was undertaken. How much of the remaining improvement was left to be done, and do you know the cost?

**Mr. McMullen:** About a third of the improvement, probably the most expensive part, because the last phase—I cannot tell you the cost; perhaps nobody in the hospital really knows—meant rewiring the whole hospital, which is quite a horrendous job. Either you tore out the walls and found the old wires and replaced them, or else you put in drop ceilings and hid all the new wiring behind the drop ceiling. That is really what the last phase was. The power exists in the hospital right up to wherever the wall jack goes back to.

**Mr. Pope:** Would that have been done by your own maintenance staff?

**Mr. McMullen:** No, that would not have been done by our staff.

**Mr. Pope:** Had you received any indication of the cost of that prior to proceeding with the first phase?

**Mr. McMullen:** I don't have that figure.

**Mr. Pope:** Could you get it for us?

**Mr. McMullen:** Yes.

**Mr. Pope:** Thank you. You had mentioned that you were looking at repairs to the cottages, or perhaps the ward areas, to help facilitate doctors. Was that part of what you consider to be a physical problem with the hospital?

**Mr. McMullen:** I would not say it was a physical problem. I would say we were trying to upgrade services in the hospital and make life easier for the patients and for the professional staff.

**Mr. Pope:** Were there any other services you had in mind to upgrade?

**Mr. McMullen:** Yes, we had dietary in mind. We wanted to revamp the ventilation system in the kitchen. I am sorry, I forgot to mention that earlier; that was another rather expensive project that ran well into the hundreds of thousands of dollars. It



would have improved the situation tremendously. We were having a few problems with foreign matter dropping out of the ceiling in the kitchen area.

Together with that particular project was another project we had, wherein we were going to establish a central dining room in the hospital for the patients. I was quite enthusiastic about this because I was looking forward to saving about \$100,000 a year by doing so. It never came to pass.

**Mr. Pope:** Had you received any estimate of the cost of these improvements?

**Mr. McMullen:** The cost of the central dining room was about \$125,000. It would have amortized itself in a year.

**Mr. Pope:** Were there any other areas in which you had begun to formulate plans for improving the services?

**Mr. McMullen:** None that comes to mind immediately.

**Mr. Pope:** Over the period of time in which you were involved in the administration of the hospital, had your maintenance budget or capital budget for repairs or replacements accelerated to any degree?

**Mr. McMullen:** At one point some years ago there was a freeze on all maintenance in the hospital. That was taken off and there was a sudden surge, there was a lot of work done. A lot of the paths that were crumbling were repaved; those roofs that I spoke about were reshingled. That type of work was carried on, so there was a surge.

**Mr. Pope:** Do you recall the differences over a period of years in the budget allocations?

**Mr. McMullen:** No, I am sorry, I cannot help you there.

[4:00]

**Mr. Pope:** Do you think the present facility should continue to be used?

**Mr. McMullen:** As what?

**Mr. Pope:** As it now is; as of January 22.

**Mr. McMullen:** That's a difficult question. I think it could continue to be used, but perhaps not in the same form as it has been used over the last half a dozen years. I think I described to you the lack of patient privacy, the cost in terms of nursing staff because of the inconvenience of the cottages, the levels that staff had to work on, the lack of elevators and things like that. So perhaps as an inpatient facility it's not the best place in the world to function from. I definitely see some uses for the facility, but not with the emphasis on inpatients to the extent that it has been in the past.

**Mr. Conway:** If I could ask a supplementary on that, Mr. McMullen, notwithstanding what you know and what the committee has been told about the additional capacity at Hamilton and at Queen Street, I'm very interested to know in connection with your last answer to Mr. Pope whether or not there is, as you see it, developing now and in the future a need in the catchment area which you in that hospital have served in the recent past for the kinds of services that you have just indicated could indeed be carried on there?

**Mr. Pope:** Community based.

**Mr. McMullen:** If you're talking about community services, yes. I think the property at Lakeshore could be very valuable in that regard.

**Mr. Conway:** Is there a need for inpatient services in that area that will not be met in your view, in your opinion? Is there a need for inpatient services such as the ones you described, in a moderated fashion perhaps, but is there a need in that catchment area now and in the future that won't be met, as you see it, by the ministry's plan to expand the use of Hamilton and Queen Street?

**Mr. Chairman:** If I may interject, I think we're perhaps being somewhat unfair to Mr. McMullen. We're getting into government policy areas and we're asking a civil servant to respond to what essentially are policy matters. Perhaps that's putting Mr. McMullen in an unfair position. I would just caution the members that it isn't really fair to do that. Mr. McMullen is here to try to be as helpful as possible, but when one moves into policy areas it puts unfair responsibility on a civil servant.

**Mr. Conway:** I accept that, Mr. Chairman, except that certainly this man is the man on the spot from this committee's point of view. I would take your guidance very sincerely and just simply indicate to Mr. McMullen if he feels the strictures of his position are such that he can't answer the question I wouldn't wish to make life more difficult for him than otherwise.

**Mr. Duksza:** Mr. Chairman, just to add to that, it was very clear yesterday that the minister consulted absolutely no one, so it would be interesting to know what his experts in Lakeshore, Queen Street and his own ministry have been saying in terms of whether it's rebuilding or continuing or otherwise. I think it becomes much more relevant to ask, and hopefully we can protect from the ministry's wrath anyone who speaks the truth here.



**Mr. Chairman:** I just threw in a word of caution in terms of embarking on a policy matter, because I think that does put a civil servant in an awkward position. Have you finished, Mr. Conway, with your supplementary?

**Mr. Conway:** I'm just wondering, given the caution of the chairman, whether you would care to comment in any way, having been there for seven years as an administrator and as an assistant administrator, as to whether or not you see inpatient needs in that catchment area that perhaps won't or can't be met by the rationalization and the greater use of Queen Street and Hamilton.

**Mr. McMullen:** Very briefly, yes, but not to the same extent that has existed in the past.

**Mr. Pope:** Apologies to Dr. Duksza, I want to ask a supplementary.

**Mr. Duksza:** I'm next. I'll wait.

**Mr. Chairman:** You're next on the list, Dr. Duksza.

**Mr. Pope:** I have one last question. In the light of your previous answer to me concerning inpatient care, would you see any disruption to the patients in alterations or improvements to the hospital in order to accommodate inpatient care?

**Mr. McMullen:** No, I don't think so.

**Mr. Pope:** How would it be handled then?

**Mr. McMullen:** I would think that certain facilities that now exist at the Lakeshore Hospital could just stand as they are and could continue to be used as they exist.

**Mr. Pope:** Would you have to move patients within the facility?

**Mr. McMullen:** That might be necessary but that's not a problem.

**Mr. Pope:** Those are my questions, Mr. Chairman, thank you.

**Mr. Duksza:** Mr. McMullen, you stated that you learned about the oncoming demise of the hospital on January 22. You said this already to me before. I understand that right now there is a discussion about the transfer of some parts of the hospital to Queen Street. We have this temporary breathing space. Could you tell me what is involved in the oncoming transfers on May 15?

**Mr. McMullen:** May 15 is the day for the transfer of cottages three and four. Cottages three and four at Lakeshore contain our admission units. At midnight on May 14, we will also be closing admissions in the hospital to all the rest of the area—that's Peel and Etobicoke—with the exception of the alcoholic admissions.

**Mr. Duksza:** I was not present at the time of that famous agreement, but I thought that there would be a staying period, according to the chairman and other members who were present, and that no decision was going to be reached until the hearings are partially over. That sounds to me as if the orders have been merely kept quiet and not changed in terms of changes in the hospital.

**Mr. McMullen:** Maybe I should have said, that it is planned to take place on May 14 and 15.

**Mr. Duksza:** But that is to plan a change of two admission units. How many new patients do you admit to cottages three and four a day?

**Mr. McMullen:** Approximately six patients.

**Mr. Duksza:** Six patients each or together?

**Mr. McMullen:** Together.

**Mr. Duksza:** Presumably you would be moving the people who are there or organizing new admissions. Are you moving the admissions or the unit?

**Mr. McMullen:** We are transferring the patients and the admissions will also be moved to Queen Street.

**Mr. Duksza:** How many patients are involved?

**Mr. McMullen:** About 108 a month.

**Mr. Duksza:** If you do the transfer on May 15, that means you must have all the plans ready at the moment and you must be proceeding with their completion.

**Mr. McMullen:** We have an inpatient committee and we have the staff from Lakeshore and Queen Street in attendance at this committee. This is what we're working towards.

**Mr. Duksza:** Have areas at the Queen Street mental health centre already been prepared for this?

**Mr. McMullen:** They are prepared to accommodate the move or will be prepared by that date.

**Mr. Duksza:** I want to go back to my original question, Mr. Chairman if you will permit me a moment to direct that question to the rest of the members of the committee. What exactly transpired? I thought there was to be a period in which no decision or no planning would take place for a month until this committee had time to discuss this?

**Mr. Conway:** It was the transfer of patients that we agreed on in the past week.

**Mr. Pope:** Thirty days after April 12.

**Mr. Duksza:** May I suggest to you that that sounds as though the minister has agreed, on the one hand, that there would be no

immediate transfer? They could not have been transferred anyway; it's clear you don't transfer over 100 patients just like that. The planning is still going ahead. I perceive that as a very inimical action. It seems perfectly pointless for me to go on if, in fact, this decision has been already reached to such a degree. They are just paying lip service, and on May 15 everything just moves forward.

**Mr. Pope:** The minister denied that the decision was made. He said it would not be proceeded with until 30 days after April 12.

**Mr. Conway:** It was my understanding that the committee, and particularly the steering committee, had reached an understanding, and the committee did seek an assurance from the minister some days ago that there would be no transfers effected before May 15. He offered that assurance. I think Dr. Duksza is raising the point of whether or not there was an assurance as to any allied planning with respect to this overall transfer, to the closing of the hospital and the transfer of the patients. Perhaps the member for Lakeshore had a different understanding from mine, but it was my understanding that we had sought and gained the minister's concession that there would be no actual or physical transfers before the 30-day period. That was the nature and the extent, as I understood it.

**Mr. Duksza:** To continue on the question, I would ask Mr. McMullen what was the original target date for transfer of cottages 3 and 4?

**Mr. McMullen:** It has always been May 15.

**Mr. Duksza:** Then the minister knew what he was doing extremely well.

**Mr. Lawlor:** There is, I would say on the basis of this information, an element of bad faith in the situation. You remember the original motion that the minister would abide by the report of this committee before effecting any further transfers; to find that he has given what my colleague calls lip service to the situation, knowing that May 15 would be the critical date in any event, I feel I've been a little misled.

**Mr. Duksza:** I feel I've been grossly misled.

**Mr. Lawlor:** I think we should communicate this to the minister.

**Mr. Duksza:** I am not sure what to do about this because I really find the whole thing quite pointless right now. I realize the basic decision is the government's and it is not for this committee to totally upset that decision, but I thought we, as a legislative committee, had reasonable freedom to question, draw our own conclusions and presum-

ably affect the government's decision at the end of it; but if it already has all been decided on, what the hell am I doing here, questioning Mr. McMullen and taking them all away from their work? They should all be packing now instead of doing this. It is perfectly unreasonable to me.

**Mr. Conway:** I would just draw to your attention, Dr. Duksza, that in his original motion Mr. Lawlor indicated as part of that motion, which was subsequently amended and I think unanimously agreed to, and I read from the original motion, "Therefore all patient transfers should cease forthwith." That was the general understanding. Now what Mr. McMullen is indicating is that really no patient transfers were contemplated before the May 15.

**Mr. McClellan:** The normal planning sequence was to make the preparations to be on time for a move on May 15.

**Mr. Conway:** But it's my understanding there had been some transfers between January 22 and March 20, or whenever this resolution was introduced. Is that not correct?

**Mr. McMullen:** That's quite true.

**Mr. Conway:** What you're saying is that none were planned further to that until May 15?

**Mr. McMullen:** That is correct.

**Mr. Conway:** And that there was no communication to you that until this committee had made a report of some kind before the early part of May, you were to cease and desist from any further transfers and none were contemplated?

**Mr. McMullen:** That's right.

**Mr. Lawlor:** Let's get straight what this motion constituted: "Therefore all patient transfers should cease forthwith and the special observation unit should be reconstituted immediately at the hospital pending the final report of this committee's deliberations."

**Mr. McClellan:** Let's face it, we've been conned.

**Mr. Duksza:** I still have questions. I just wanted to establish that the committee has been conned.

**Mr. Chairman:** You're suggesting we won't send our people packing until tomorrow, Dr. Duksza?

[4:15]

**Mr. Duksza:** Well I don't know. Presumably this committee will have to come to some decision as to whether we are going to advise the Legislature that the hospital should stay as it is or be rebuilt, or whether the hospital should be coalesced with the Queen



Street Mental Health Centre, but I want to have some freedom of action. If the majority of the members finally come to the conclusion that indeed there should be the coalescing and the building of one large total institution, that's fine, I will accept it. Although both intellectually and as a professional it is against my grain to agree with it, nevertheless I will agree. All I want assured is that my "privileges as a member" are not being played with by the minister, who simply thinks that I am a fool who comes here and can play the tune as he wants me to play it.

**Mr. Jones:** Talking about playing, you keep talking about one big institution; does that mean you are talking about 1848 and the return to one big institution?

**Mr. Duksza:** Yes, that is exactly what the minister has done, combined them.

**Mr. Chairman:** Well, perhaps we could carry on now.

**Mr. Duksza:** Can I go on? I have three questions, really, and they are fairly lengthy ones.

Could you tell me something about the programs that you, as administrator, are responsible for, and the areas in which you think in some sense Lakeshore has been a leader in the field in some of this programming? Perhaps you could list those things and then tell us what you think is the value of these programs.

**Mr. McMullen:** The programs, as you know, cover the five essential services which you know about. To that end we have an alcoholic service, we have vocation and recreation, we have an outpatient program called DARE, we have behaviour therapy, we have speech therapy; I am probably missing some but these, generally, are the programs we have. From the way you are looking at me I can tell I haven't answered your question, maybe you could go through it again.

**Mr. Duksza:** No, no. There are other programs, for example you have extensive research—

**Mr. McMullen:** That is quite true, dialysis; haemodialysis for schizophrenia.

**Mr. Duksza:** Yes. You also have this research department, largely based in the department of psychology, and one of the questions I would have is do you still have the linkage with the University of Waterloo?

**Mr. McMullen:** That is correct.

**Mr. Duksza:** You have a link with them?

**Mr. McMullen:** We have.

**Mr. Duksza:** That involves cross-appointments, staff cross-appointments; or what does it involve actually?

**Mr. McMullen:** I am not sure. I am sure Dr. Bond can enlighten you more on that.

**Mr. Duksza:** But you do have students from—is it the University of Waterloo or Wilfrid Laurier?

**Mr. McMullen:** No, it is Waterloo.

**Mr. Duksza:** Waterloo; and you have students who are seconded?

**Mr. McMullen:** We do have students, yes.

**Mr. Duksza:** Has there been much of a discussion between—I know Dr. Bond may answer this in much more detail, maybe we should get someone from psychology to answer some of these questions; but has there been discussion between the University of Waterloo and Lakeshore psychiatric about the future of the programs?

**Mr. McMullen:** Once again, I think Dr. Bond should speak to that; not me anyhow. I mean there has been no discussion with me.

**Mr. Duksza:** I am curious as to whether they know, except from the papers. Maybe the minister did not manage to tell them.

The children's mental health unit, of course, is now under ComSoc. It is one of the things which Lakeshore pioneered, in some sense. If I was speaking on your behalf I would say that the hospital has pioneered a number of major programs, which were based in the hospital or outside in an interesting mixture for provision of services, both inpatient and outpatient.

**Mr. McMullen:** Quite true.

**Mr. Duksza:** What are you proud of in your hospital, which would be lost in the transfer?

**Mr. McMullen:** I think that I am very proud of the research being done in dialysis. I know that Lakeshore is one of the fore-runners in chemotherapy. I think that Lakeshore was probably among the first hospitals to begin to get patients into the community, out of the hospital. I think that Lakeshore has had a very good track record over the years.

**Mr. Duksza:** That, I hope, will continue.

In my third question I want to return to the McKinsey role study. This has been going on for some time. I remember a year when I was still a health critic questioning the then minister about the McKinsey report. He was rather enthusiastic, since he had just commissioned it at great cost, that particular study. He said to wait for the final results and that,



for one thing, it had been going extremely well. All the experts had been involved in it. There had been massive consultation among the three hospitals and the various facilities, the ministry and himself. In fact, he supported then—we only dealt with the second part of the report; not the final one—he supported then most of the recommendations. I remember it distinctly; it can be checked from the Hansard of that particular occasion.

How much were you really involved? The question is now, really, how much the hospital was involved and you directly in the hearings, input, papers and advice in connection with the McKinsey study?

**Mr. McMullen:** I believe we had a committee called the steering committee at the time, chaired by the general manager. I was on that committee.

**Mr. Duksza:** How often did it meet?

**Mr. McMullen:** Approximately once a month.

**Mr. Duksza:** Once a month, for how long?

**Mr. McMullen:** Six or seven months; the length of the role study.

**Mr. Duksza:** That was the hospital-wide committee?

**Mr. McMullen:** That's correct.

**Mr. Duksza:** All the departments were represented?

**Mr. McMullen:** Within the hospital, yes.

**Mr. Duksza:** While this was going on, was there input from other people besides the members of the steering committee? From the hospital into the study?

**Mr. McMullen:** From the department heads in the hospital to the hospital administrator to the steering committee.

**Mr. Duksza:** It went that way?

**Mr. McMullen:** Yes.

**Mr. Duksza:** Were there actually formal papers which were presented to it?

**Mr. McMullen:** Some were in the form of papers; others were providing information to the consultants who had visited the hospital.

**Mr. Duksza:** How many hours would all that involve?

**Mr. McMullen:** A great many.

**Mr. Duksza:** In effect, the whole hospital was involved, and the staff had a significant intellectual input into the study, if I am correct.

**Mr. McMullen:** Quite correct.

**Mr. Duksza:** So in substance, many of the recommendations of the McKinsey role study are in fact your recommendations and those of your staff?

**Mr. McMullen:** Yes.

**Mr. Duksza:** It must have put you in a very interesting position when suddenly something that comes out from the professionals, from the department itself, from almost everyone who is concerned about the future of the psychiatric services in Metro, is rather unilaterally destroyed by Mr. Miller—excuse me; Mr. Timbrell, of course, I should have said.

**Mr. Lawlor:** Miller has his role.

**Mr. Duksza:** If this involvement was so complete, and you were in such agreement, how does it make you feel right now about that? I have to ask those questions, Mr. Chairman, because there is such a discrepancy between what the professionals have suggested and what is embodied in the report, and what the minister is doing. I think I have to at least find out from a professional point of view from Mr. McMullen. Will you allow those questions?

**Mr. Chairman:** Well, from a professional point of view, rather than a policy of view.

**Mr. Duksza:** Yes. Maybe Mr. McMullen will answer those questions. I will ask those questions of Dr. Bond and a couple of other people. I would like to know Mr. McMullen's own feeling on the most significant portions of the McKinsey report which are his own work, how he feels about those recommendations.

**Mr. McMullen:** I suppose I was most enthusiastic about the possibility of having a new hospital. Certainly it was needed for all the reasons that I've already mentioned here this afternoon.

It was my opinion that it satisfied the needs of Metropolitan Toronto and the surrounding areas. It made good use of the change recommended in catchment areas, made good use of all the beds in the area. It satisfied the vacant bed situation that existed in Queen Street. It anticipated the expansion in population in the west of the city, through Mississauga, out through Peel and that sort of thing. And for those reasons I was quite enthusiastic about the recommendations of the role study.

**Mr. Duksza:** An obvious one you mentioned, the changes in the catchment area; clearly the Queen Street Mental Health Centre only covered, I think, a catchment area of 750,000 people. It was logical to extend it to parts of Metro Toronto, which I think is what the role study has recommended very strongly. If those changes in catchment area had been implemented, how large a catchment area would have been left to the Lakeshore Psychiatric Hospital?

**Mr. McMullen:** The population of our catchment area was in the order of 1,400,000, I believe. The change in catchment probably would have brought us down to about—I am sure the figures are contained in the McKinsey role study, and I would not want to misquote it, but I think it would probably bring it down to perhaps 600,000, and then the anticipated growth over the next 10 years would bring it back up again.

**Mr. Duksza:** I'm sorry; I don't remember myself the anticipated growth as articulated in the McKinsey study. Do you remember that?

**Mr. McMullen:** No, I don't remember.

**Mr. Duksza:** I think it was a 37 per cent growth rate; so, in fact, your catchment area would have grown quite significantly. That is one of the recommendations—the catchment area. That is very logical; it has perhaps been overdue for some time, that a large institution like Queen Street could take more responsibility for Metro and take over some of the things that you have been carrying.

When Mr. Foulds was asking you some questions, you were very careful in saying that it is difficult for you to go against the decision of the department since in that sense you are directly responsible for people in the department of health. But you carefully said that, as it is right now, you accept that something has to be done. You didn't really specify what should be done. Maybe you could elaborate on that for me. Let me help you with this.

**Mr. McMullen:** Yes, please.

**Mr. Duksza:** There are two ways of looking at this: You close the hospital and you have one big catchment area. Half is hewed off to go to Hamilton and the rest comes under the Queen Street Mental Health Centre. One way of doing it is one large hospital. Mr. Terry Jones objects to my usage of the term "total institution." I will not use it; I will say one large hospital.

The other way of doing it is, if the physical plant is that unacceptable to so many people—and I have some questions of it—if it is in fact not as private or as elegant in some sense as Queen Street Mental Health Centre is right now, the alternative of course is rebuilding. Then the question is not one of closing it but what kind of rebuilding, whether it is just upgrading. And where will the building occur? I wonder if you could comment on those four theses that I have presented you with, so to speak.

**Mr. McMullen:** I will try. You have already mentioned children's services. We

have our community orientation centre for the retarded. We have an alcoholic service. We have behaviour therapy and speech therapy. I think it is quite conceivable that those programs could continue in Lakeshore Psychiatric Hospital with some slight, limited amount of renovation to the facility. Does that answer the question?

[4:30]

**Mr. Duksza:** Those can continue at the present physical facility that both you and the hospital and, finally, the outcome of your thinking is the McKinsey role study suggested that you, in fact, have to rebuild. Have you, in that sense, believed that the main important thing is rebuilding the hospital more than closing it, Mr. McMullen?

**Mr. McMullen:** I guess it really boils down to how long the ministry decides that it wants to run some sort of mental health care facility in the Lakeshore area. If it comes to building, then I think it would be time to run through another demographic study to discover just precisely where it would be located.

**Mr. Duksza:** In effect, you are saying that it could be rebuilt in the present Lakeshore area or it could be rebuilt somewhere else, and maybe a demographic study needs to be made. For example, maybe some people would suggest that a Halton-Peel centre would be much more appropriate, smaller but appropriate; or two centres, one on the Lakeshore and one in the Halton-Peel area somewhere. I accept that. It's perfectly acceptable, because Lakeshore Psychiatric Hospital is in the lower part of the catchment area.

I'm sorry to put you under so much pressure, because I know that it is difficult for you to answer it, but what you're really saying is that it should really be rebuilt but the political decision to close or not to close, of course, is taken on a different level. Am I right in saying that you, in effect, support your own original input into the McKinsey report, which is that the hospital should be rebuilt?

**Mr. McMullen:** Yes, quite.

**Mr. Duksza:** That is all.

**Mr. McClellan:** I'll try to be brief, because there are a number of other witnesses and some of the material that I wanted to ask you about has been covered, Mr. McMullen. When did you receive volume one of the McKinsey report?

**Mr. McMullen:** I think the report is dated January 1978, is it not? It would have been just about that time.



**Mr. McClellan:** Were you ever asked for a response from the ministry to the recommendations of the report?

**Mr. McMullen:** No.

**Mr. McClellan:** You weren't ever asked to cost one or other of the options?

**Mr. McMullen:** No.

**Mr. McClellan:** Okay. So did you have any participation in any planning discussions at the ministry level with respect to the McKinsey recommendations?

**Mr. McMullen:** Yes, I was a member of the steering committee.

**Mr. McClellan:** This is following the completion of the McKinsey report, once the report had been received?

**Mr. McMullen:** Not after the report was published, right.

**Mr. McClellan:** The other area I wanted to ask you about was with respect to the outpatients' services. I assume that your job for the time that you remain at Lakeshore is to ensure the orderly transfer of patients, and secondly, I would assume, to keep the outpatients' services going. Is that an accurate summary?

**Mr. McClellan:** That's quite true, yes.

**Mr. McClellan:** In the ministry fact sheet that has been distributed throughout the community to everybody except members of the Legislature—it eventually was distributed to the members—there is this statement on page three: "At Lakeshore today, there are a number of excellent outpatient mental health programs in operation such as the DARE program, the alcoholism program, behaviour modification program and the general outpatient program. These need not be hospital based. They will continue with no disruption in service although administrative responsibility will shift to Queen Street."

I take that to mean that those programs will continue to run until such time as there is some alternate arrangement for them to be run out of the Lakeshore premises, is that correct?

**Mr. McMullen:** I suspect you're correct.

**Mr. McClellan:** The alcoholism—the DARE program continues without staff cuts, I would assume.

**Mr. McMullen:** That's correct.

**Mr. McClellan:** The speech therapy program continues without staff cuts, and the Community and Social Services programs continue without staff cuts.

**Mr. McMullen:** Quite so.

**Mr. McClellan:** What about the behaviour therapy clinic?

**Mr. McMullen:** That would continue also.

**Mr. McClellan:** I had understood that there were some staff cuts in the behaviour therapy clinic; is that correct?

**Mr. McMullen:** There were what? I'm sorry.

**Mr. McClellan:** There were some staff cuts—

**Mr. McMullen:** Not that I'm aware of.

**Mr. McClellan:** —in the behaviour therapy clinic; that four of the six staff in the behaviour therapy clinic had been advised that they were within the group to be laid off.

**Mr. McMullen:** I'm sorry; I wasn't aware of that situation. I didn't know we had six staff in the behaviour therapy group. That's a rather unique program. It's really 90 per cent operated by volunteers.

**Mr. McClellan:** Is there somebody with you, with your group, who would have a clear sense of—you see my information was that there were six staff, including the director, who I believe is a Dr. Neiger. Is that his name?

**Mr. McMullen:** That's correct.

**Mr. McClellan:** And that a person whose responsibilities involved some teaching, two part-time staff people who co-ordinated volunteers, and the secretary of the unit, were within the group who had received layoff notices.

**Mr. McMullen:** I'm sorry; I'm surprised. I didn't know, if that situation is indeed a fact.

**Mr. Chairman:** Perhaps we could get that clarified from some other witnesses later on.

**Mr. McClellan:** Would there be somebody, Mr. McMullen, who it would be appropriate for me to ask?

**Mr. McMullen:** Dr. Bond may be able to help you in that area.

**Mr. McClellan:** I'll hold that over then. Your understanding, with respect to what you're supposed to do as administrator during this period, is that the outpatient programs are to be maintained intact with the present staff complements until alternative arrangements—so that you would be surprised if there were staff cuts in the behaviour therapy clinic.

**Mr. McMullen:** I would.

**Mr. McClellan:** Thank you very much.

**Mr. Chairman:** I should caution members of the committee that we have eight other people from whom we have to hear and we've been an hour and 20 minutes, or



thereabouts; so I would hope that we could move quickly along.

**Mr. Duksza:** How can we manage, especially since we have a vote, I understand, between five and six?

**Mr. Chairman:** I wasn't aware of the vote.

**Mr. Duksza:** Anyway, how can we rush through eight witnesses?

**Mr. Chairman:** All I am saying to you is that these are busy people. They have been asked to come here today. If the committee wishes them to come back tomorrow, I'm in the hands of the committee. I just wanted to let you know that we have a lot of other work we have to do today and we have to move along.

**Mr. Duksza:** I understand that the steering committee had set this up.

**Mr. Rowe:** I imagine, Mr. Chairman, there have been a lot of questions asked of Mr. McMullen that probably would have been as appropriate somewhere else; so we may be able to handle it.

**Mr. Chairman:** Mr. Johnston?

**Mr. R. F. Johnston:** I only have two questions, and I hope they're directed to you as administrator. One was, you made a comment in passing in response to something by Mr. Pope to do with the fact that there were rosy prospects at one point for implementation of the McKinsey report. In replying to Mr. McClellan, you said that you had no further input into McKinsey decision-making, if you will, after the report was released. Can you tell me when you thought prospects were rosy and why you said that?

**Mr. McMullen:** Well, the recommendations contained in the McKinsey report were in harmony, I think, with the feelings of everybody in the hospital; at that particular point in time there was no reason to believe that the ministry would do anything but adopt those recommendations. That is why I said it was rosy.

**Mr. R. F. Johnston:** Did the ministry officials give you that impression as well, that they liked the report? That they thought—

**Mr. McMullen:** I am not sure I would say the ministry officials said that in so many words. I think it was an atmosphere that existed; you got that feeling.

**Mr. R. F. Johnston:** So when the decision was made in January, you were surprised; is that accurate? The decision to close Lakeshore?

**Mr. McMullen:** No. I suppose it didn't really come as a surprise. Lakeshore has had

its troubles for many years; there were questions of closure; there were questions of divestment and then closure and then divestment and then closure. So we weren't really surprised.

**Mr. R. F. Johnston:** One of the things that comes across to me in the way you talk as an administrator is that you talk very positively about your staff, from maintenance on through, in your comments. With the kind of atmosphere that surrounded Lakeshore, the kind of thing you say—closure, divestment, that kind of thing—it is remarkable to me that there might be things like staff stability. Was that the case with your senior staff, as an example? I know some psychiatric institutions have had a lot of trouble maintaining sort of stable staffing relationships.

**Mr. McMullen:** I think that Lakeshore has been blessed with a very loyal and dedicated group of people throughout: medical staff, nursing staff, support services, everything; they have been excellent.

**Mr. R. F. Johnston:** And that is in spite of that kind of pressure that is placed on it?

**Mr. McMullen:** Quite.

**Mr. R. F. Johnston:** And you also said you felt that it had—and it is my impression, as well—a remarkably good relationship with the community—

**Mr. McMullen:** I believe so.

**Mr. R. F. Johnston:** —for a psychiatric institution, which usually has some difficulties in that area.

I guess what I was trying to get at with the other question was that it seems strange to me that, during the period of a year that the report was sat on basically, there would not have been some sort of interaction between those who help advise the minister, as it were, or senior members of the Health ministry and the administrators of the various hospitals, the three hospitals involved. Although you were not party to any discussions in that way, were there any position papers, any briefs, or anything like that coming out of McKinsey, that found themselves on your desk at any time—from the ministry end of things?

**Mr. McMullen:** Not to my knowledge, no.

**Mr. R. F. Johnston:** Okay. Thank you very much.

**Mr. Sweeney:** May I ask a supplementary? A term was used, and I am not sure of the sense in which it was used; that's all.

**Mr. Chairman:** Mr. Sweeney?

**Mr. Sweeney:** In what sense did you use the term "divestment" a few minutes ago?

**Mr. McMullen:** What I was referring to is placing the hospital under a board of directors.

**Mr. Sweeney:** As opposed to under the—

**Mr. McMullen:** Ministry.

**Mr. Sweeney:** Okay.

**Mr. Chairman:** Mr. Lawlor?

**Mr. Lawlor:** No. It is okay; I'll go on to the next witness.

**Mr. Chairman:** Mr. Pope?

**Mr. Pope:** Just briefly, you had a planning committee that you referred to which dealt with the particulars of patient transfer and closure of certain segments of the hospital. When did your committee decide to close cottages three and four?

**Mr. McMullen:** I don't think the committee ever really decided on a particular date. It is an end that we have been working towards. Really the decision rested on the ability of Queen Street to accommodate the patients. We had a rough target date, you know, during May; and when Queen Street resolved their in-house problems and made arrangements on their wards to accommodate the patients to be transferred, then we established the date.

**Mr. Pope:** The establishment of that date, when did it take place?

**Mr. McMullen:** A week ago Friday.

**Mr. Pope:** Right. Thank you very much.

**Mr. Chairman:** Thank you very much, Mr. McMullen. We appreciate your attendance, and we hope it hasn't been too onerous for you.

**Mr. McMullen:** Thank you, Mr. Chairman.  
[4:45]

**Mr. Chairman:** Dr. Bond, the medical director for the Lakeshore Psychiatric Hospital.

**Mr. Conway:** Mr. Chairman, I will try to restrict my comments to just a few questions.

**Dr. Bond,** what exactly is involved in your capacity as medical director at Lakeshore? could you briefly outline what it is you do and what you're responsible for?

**Dr. Bond:** Well, I'm the department head of the medical staff, of course, and I'm responsible for all the clinical departments and for programs and treatment.

**Mr. Conway:** How long have you been at Lakeshore?

**Dr. Bond:** Fifteen-years.

**Mr. Conway:** You've had a long experience there in the course of those years. As medical director at Lakeshore, how do you feel about the transfer that is being effected and, in

particular, about how it will impinge upon the quality of service that will be afforded to the people you are going to lose at Lakeshore and who will find themselves in either Queen Street or Hamilton?

**Dr. Bond:** Well, perhaps I should preface my answer by saying, as Mr. Chairman pointed out, that as a servant of the crown, of course, I don't have any say in policy and I have to give you my private opinion. I think the move is a most regrettable one.

**Mr. Conway:** Could you expand on that? I fully accept and expect you to give us your private opinion in that connection. Can you indicate how it is you see that as regrettable, particularly in your capacity as a doctor?

**Dr. Bond:** Well. I find it difficult to defend on clinical grounds. Of course, I'm not conversant with the political and economic factors but it seems irrational to close the facility which has the highest admission rate. It is the busiest psychiatric hospital in the province in the fastest-growing urbanized area. And also, by the closure you, ipso facto, enlarge Queen Street into a very large institution, which is rather retrograde to modern ideas on the size of psychiatric hospitals.

**Mr. Conway:** Just in that connection, we were told yesterday by the minister that Queen Street, as it will be amended with this transfer, while becoming larger than it was, won't be out of line in terms of patient load with other psychiatric hospitals. How do you respond to the basic point that enlarging Queen Street is no real worry since other provincially operated and owned psychiatric institutions are of a similar order? London was mentioned, for example, as—

**Dr. Bond:** I would like to point out that you're just talking about the number of beds. That is not the important factor. It's what is done with those beds. You can have a hospital with 1,000 beds with no movement at all, or you can have a hospital with 300 beds that processes thousands of patients and that is the case with Lakeshore.

We had an admission rate of about 200 or 250 a month which we processed through 331 beds. In other words—I forget the term there — our turnover of beds was phenomenally high compared with other institutions. So, although Queen Street will have, I believe, in the order of 600 or something beds, which is within range of other hospitals, unless the general hospitals take up more of the slack, they will be processing what we processed. Last year there was about 2,200 patients per annum. Two years before that, it was 3,500. There has been a reduction, of course. What I'm saying is that Queen Street will be a very



busy hospital, irrespective of the number of beds.

**Mr. Conway:** And from what we know about the public hospital budget situation, it's not altogether likely that they will find themselves in a position to effectively deal with this kind of spillover. Would that be a reasonable assumption?

**Dr. Bond:** I don't know. That depends on the Treasury Board; I can't speak about that.

**Mr. Conway:** Now, I'm interested to pursue a little further the point—and I think a very important point—that you've made about the busy-ness of Lakeshore. Could you just expand on that a little further, indicating why your facility was so busy? Was it principally because of the community-based services that it offered, more so than other hospitals?

**Dr. Bond:** Basically, it was because of the population base. We had a population in the western area of nearly 1.5 million, growing at approximately 10 per cent, which in itself is probably about the population of Saskatchewan and Manitoba put together. So, Queen Street will end up almost serving three Norways. It was just simply numbers.

You also have to remember that the psychiatric hospital served the disadvantaged population in sections of our catchment area. Just as Queen Street has the problem of high-density public housing with a very high incidence of mental illness, so we had certain areas from which we had a big input.

**Mr. Conway:** From what you know of Queen Street, I assume from what you've said that you have grave doubts about the capacity of that institution to deal with the load transferred there as a result of the closure of Lakeshore, both in the sense of dealing with the expansion in the catchment area over the next few years and, in particular, in dealing with that kind of clientele you dealt with at Lakeshore. In other words, in terms of absolute beds, it may be able to handle the pressure in the short-term, but the busy aspect will place great burdens on that Queen Street facility?

**Dr. Bond:** I'm not saying Queen Street can't handle it. I mean you can go back to the old days—you can just squeeze patients in. I don't know what effect that will have on their programs. I'm not conversant with Queen Street programs.

I don't know whether they'll get the same number of admissions from our area which we did. Perhaps distance itself will reduce it; I don't know that police will want to

take people long distances. I don't know, of course, what is planned for the general hospitals in that area—whether they can expand their services. Perhaps they can. I think there should be some relief from that area.

**Mr. Conway:** It seems not unreasonable to assume that, given the situation in which most hospitals find themselves today, they're going to be at best hard-pressed to meet present, to say nothing of expanded, requirements.

**Dr. Bond:** If the present trends continue. I don't know whether years ago anyone foresaw the reduction in the inpatient populations. What has happened, of course, is not peculiar to Lakeshore, by the way. It's a world-wide phenomenon. It's due to the introduction of phenothiazine drugs mainly, but also to the emergence of general hospital beds, which looked after the less severely ill. Prior to World War Two, of course, all psychiatric treatment was carried out only in psychiatric hospitals. I don't know if I've answered your question.

**Mr. Conway:** I'm gathering from what you're saying that certainly there is very strong likelihood that the quality of psychiatric care available to many people in that catchment area—particularly the group in the public housing sector that you've mentioned—is very likely to deteriorate.

**Dr. Bond:** Well, I wouldn't like to make an invidious comparison between Queen Street and Lakeshore. I think the patients, once they get there, will get very adequate treatment. It will perhaps be inconvenient for the families for visiting purposes.

**Mr. Conway:** That's all for the moment, Mr. Chairman.

**Mr. Leluk:** Dr. Bond, the members of this committee have been given the indication that the buildings at the Lakeshore Psychiatric Hospital are not quite what they might be in terms of their physical qualities. The programs are of a high quality and this is largely due to the efforts of yourself and your staff. Now as the medical director, could you describe for us the efforts that your staff have made to contend with or counteract the limitations of the present facilities at Lakeshore?

**Dr. Bond:** I find that rather difficult to answer. I think it's mainly through an excellent maintenance department. Whenever we want to introduce a new program, it always requires renovation. They seem to be on the spot and do it very quickly. I think without them we could never have



done it. So, it's a matter of patch and change all the time internally.

**Mr. Leluk:** But they have found certain limitations because of the present physical facilities and they've had to—

**Dr. Bond:** Yes. The worst disadvantage is the cottages being on three tiers, with no elevators. The nursing staff have done wonders, of course, in making the place more comfortable for the patients.

**Mr. Leluk:** Could you, in your own words, describe for the members of this committee how the Queen Street facility compares with the present Lakeshore facility?

**Dr. Bond:** You mean, physically?

**Mr. Leluk:** Yes.

**Dr. Bond:** There's no comparison. One is a modern, lavishly endowed hospital and the other one is not. It's an 89-year-old hospital which has had very little done to modernize it.

**Mr. Leluk:** Have you, or some of your colleagues, had complaints by patients at this facility about the present physical facilities such as the lack of privacy and what-have-you?

**Dr. Bond:** Strangely enough, I have never heard a patient complain. I've had staff complain regularly, of course. I've heard some family members complain about the facilities.

**Mr. Leluk:** Have any of your colleagues, to your knowledge, ever received complaints from patients about the lack of privacy in these ward-like rooms?

**Dr. Bond:** Not to my knowledge. Most of the population, of course, are schizophrenic patients and they don't seem to value privacy, although I'm not saying they shouldn't have it. But they don't seem to complain.

**Mr. Leluk:** I see. In your professional capacity, do you feel that the psychiatric services presently being provided by general hospitals in the Lakeshore catchment area, have been adequate, would you say?

**Dr. Bond:** This is a very difficult question because you really have two systems in action. There are the general hospitals. We don't really have regional hospitals in Toronto, as you know.

**Mr. Leluk:** I'm talking about the psychiatric units in general hospitals.

**Dr. Bond:** In general hospitals. They're run on a private practice-entrepreneurial sort of philosophy while the psychiatric hospitals are run on a more, you might say, socialistic method.

**Mr. Lawlor:** Don't say that to Mr. Leluk. That will torture him.

**Mr. Leluk:** It's quite all right, Patrick.

**Dr. Bond:** Perhaps I used the wrong term.

**Mr. Lawlor:** Great term. It's okay.

**Dr. Bond:** The general hospitals can handle, quite well, all psychoneuroses and the depressions and a good deal of the psychotics.

What they are not equipped to handle, and it's not they won't but they can't, are the very violent, the very chronic, the personality disorders, and the brain-damaged—these sort of people. So, in answer to your question, I'd say, on the whole, our general hospitals have given very adequate service. Obviously our admission rate would not have dropped during that period of time if they hadn't.

**Mr. Leluk:** Yes. Which leads me to the next question.

Do you believe that the inpatient treatment in the psychiatric hospitals should be reserved for those patients who cannot be treated in other settings such as the backup or the special treatment facilities?

**Dr. Bond:** That is my belief, yes. I think that it's obviously an advantage if a patient can be treated in a general hospital.

**Mr. Leluk:** This being the case, does it really matter, then, as a physician, a psychiatrist, whether the hospitalization is available within say a one-mile, five-mile or 10-mile radius or, as is the case in most of the province, from one to 300 hundred miles from the place where the patient might reside?

**Dr. Bond:** I think it's still an important factor that families can live close to the patients, irrespective of their disability. I know that in our retarded units, surprisingly enough, the families are very zealous in visiting. So, I don't think chronicity has anything to do with the humanity factor.

**Mr. Leluk:** Of the patients requiring psychiatric help, what percentage would you say ever required hospitalization in a psychiatric hospital facility?

**Dr. Bond:** I'm sorry. I didn't get the beginning of that question.

**Mr. Leluk:** Of all patients requiring psychiatric help, what percentage would you say required hospitalization in a psychiatric hospital itself? We've heard figures thrown around that a decade ago we had, say, 16,000 patients in psychiatric institutions and now we have about 4,000, which doesn't necessarily mean that we have fewer patients requiring a service but, the modality of treatment is moving out into the community. Would you agree with that and can you give us some kind of a ballpark figure? I'm not looking for an exact figure, but some ball-

park figure of the percentage that would require hospitalization in an institutional setting, for example?

**Dr. Bond:** By institutional, are you including the general hospital?

**Mr. Leluk:** No, I'm talking about psychiatric hospitals.

[5:00]

**Dr. Bond:** It would only be a very wild guess, I suppose. It's very hard to get at the morbidity in the population. Maybe 20 per cent? I'm just guessing.

**Mr. Leluk:** Would you agree with the earlier statement I made that the modality of treatment has moved into community programs?

**Dr. Bond:** Yes.

**Mr. Leluk:** That leads me to the next question. Is it possible that the Lakeshore Psychiatric Hospital is providing what we call primary psychiatric services and aftercare rather than, say, the tertiary type of care that the facility happens to be? In other words, what I'm saying is that these primary services and aftercare might be provided by, say, general hospitals with psychiatric units. Would you say it's possible that maybe the Lakeshore Psychiatric Hospital is providing primary psychiatric services and aftercare which could be provided in a general hospital setting?

**Dr. Bond:** If we go back before the dissolution, so to speak, of January 22, prior to that I think our hospital was operating both as a chronic and an acute-care facility which, in my opinion, was not the correct role of psychiatric hospital. We should, as far as possible, be dealing with the long-term chronic and particular problems. I think I've forgotten the line of your question. What was it again?

**Mr. Leluk:** What I was saying was, could it be possible that the Lakeshore Psychiatric Hospital is providing these primary psychiatric services and aftercare which could be provided in a general hospital setting, say in one of their psychiatric units?

**Dr. Bond:** A great deal of it could be, but there would have to be considerable expansion of general hospital facilities.

**Mr. Leluk:** So they can provide this type of service that is being provided?

**Dr. Bond:** They can. But, as I said before, we got a lot of patients from them because they were full up. They had patients in the corridor; they couldn't take any more. We got patients they normally would have handled.

**Mr. Leluk:** When the psychogeriatric patients were being transferred recently to the Queen Street Mental Health Centre, did the television cameras and the pickets which were established at the Lakeshore Psychiatric Hospital affect these patients in any way, in your medical opinion?

**Dr. Bond:** I don't think so.

**Mr. Leluk:** Have you heard how these patients might be doing now, since they've been transferred and settled into the Queen Street Mental Health Centre?

**Dr. Bond:** I understand they're very comfortable.

**Mr. Leluk:** Doing fine?

**Dr. Bond:** Yes, sure.

**Mr. Leluk:** There were some allegations made that the Lakeshore psychiatric patients transferred had been handcuffed and threatened with violence if they did not agree to the transfer. Did you, as the medical director, permit this to happen? Do you know where these rumours originated or whether, in fact, they are rumours?

**Dr. Bond:** I haven't the faintest idea. I have no knowledge of any such activities.

**Mr. Leluk:** I believe that Mr. Lawlor, the member for Lakeshore, made some allegations to the effect that patients were handcuffed. Is that right, Patrick?

**Mr. Lawlor:** Mr. Leluk, we haven't pressed that issue; and it's probably not true.

**Mr. Leluk:** But you made a public statement. I recall reading it in the local paper out in Etobicoke. That's why I'm asking you.

**Mr. Lawlor:** I hope the ministry aren't supplying you with these silly questions.

**Mr. Leluk:** No, they're not. But I think when a member makes a statement publicly, then he should either refute that statement or stand behind that statement. I am asking Dr. Bond.

**Mr. Lawlor:** That was the information we were supplied with at the time, and it was wrong. Are you happy?

**Mr. Leluk:** I was asking Dr. Bond that because he is the medical director and I was just putting the question to him whether in fact this occurred.

Just one last question, Dr. Bond. What might your own personal plans be now that the Minister of Health has announced the closing of this facility as of September 1?

**Dr. Bond:** The ministry has offered me a position at Whitby Psychiatric Hospital.

**Mr. Leluk:** No other questions, Mr. Chairman.



**Mr. Chairman:** Mr. Lawlor?

**Mr. Lawlor:** Mr. Chairman, I have quite lengthy questioning. I have been looking forward to seeing Dr. Ian Bond. The chief weight is going to fall in this area; so I guess we might as well get started.

Doctor, what input did you have in the McKinsey?

**Dr. Bond:** What input? Like all the senior staff there I was questioned and took part in the study. The McKinsey staff interviewed me and asked my opinion, and for statistics and that sort of thing.

**Mr. Lawlor:** You attended these meetings that have been mentioned over a period of some months?

**Dr. Bond:** Yes.

**Mr. Lawlor:** You were fairly cognizant of what was going on, at least from the point of view of the input from that hospital?

**Dr. Bond:** Yes.

**Mr. Lawlor:** Have you any objections to the contents of the McKinsey report that has come out?

**Dr. Bond:** None whatsoever. I thoroughly agree with it.

**Mr. Lawlor:** You thoroughly agree with it. You're in charge of the dialysis unit at the hospital?

**Dr. Bond:** Yes.

**Mr. Lawlor:** Is it your understanding that is to be transferred to Whitby and the number of dialysis units to be increased?

**Dr. Bond:** Yes.

**Mr. Lawlor:** How many patients are there, by the way, at the present time?

**Dr. Bond:** Perhaps I could just briefly tell you something about it. This was a research program which we at Lakeshore felt should be embarked upon. We started about one year ago, following Wagemaker and Cade's reports from the United States in which they more or less accidentally discovered that if schizophrenics were haemodialysed a percentage of them lost their symptomology. It seemed important that this be replicated. We were able to embark upon a double blind study with a very generous grant support from the PSI foundation. This research really is of international importance. We are in contact with other countries doing similar studies. As a matter of fact, at the moment the Lakeshore study is the only one in the world which is a double blind.

Unfortunately, it was a blow when the closure was announced and, in effect, the project was severely damaged, but we intend to see it through. We have changed course

slightly. We have had to put in a two-phase program, one to be completed at Lakeshore, and then we will start another one if it goes to Whitby.

The choice of Whitby was a fairly practical one because you can't do a study of this nature in a shifting sand, so to speak. You must have some security. The very fact of moving it brings in variables which throw the whole study out, and of course with the disruption of staff and staff leaving we are in a very perilous state. It's very important that it be clarified as soon as possible where it's finally going to go.

Whitby offered security and excellent facilities to carry it out and also protection of the staff. One of the main reasons we went there was that it wouldn't have been possible to take all the staff into Queen Street. The plan was to increase the number of machines from four to eight, simply because some of the patients who recovered are now demanding maintenance treatment. It's going from research into a form of treatment.

**Mr. Lawlor:** I understand that your important research project is in some jeopardy because of the move itself and that the disturbance the announcement created in the schizophrenic patients, et cetera, may introduce a factor into your analysis, an unknown element that may be disruptive of your present results. Is that so?

**Dr. Bond:** That's so. The actual moving from one environment to another.

**Mr. Lawlor:** Secondly, these patients in very close proximity to the Lakeshore facility at the moment will have to be transported by bus to Whitby.

**Dr. Bond:** That is not totally correct. We have patients from everywhere. A great number of them are from the Toronto area, but we have them from as far away as Niagara Falls and even Peterborough. The ministry was going to facilitate that. The patients would have been subsidized for their extra travel.

**Mr. Lawlor:** They will have to meet a bus at a certain place?

**Dr. Bond:** That is right, and they will be given subsidized travel.

**Mr. Lawlor:** And the feeling is it would take about half a day at least to do that?

**Dr. Bond:** Yes, that is about it.

**Mr. Lawlor:** Just a word from the McKinsey report, in confirmation. At page nine, summing up the first chapter: "From our work over the past 22 weeks, we are convinced that each of the three psychiatric hos-



pitals is essential"—that is the word I want to put here—"long term to the effective provision of psychiatric care to the people of greater Toronto." You accede to that statement?

**Dr. Bond:** I would agree with that, yes.

**Mr. Lawlor:** Is it true that about 50 per cent of the patients at Lakeshore live within a five-mile radius?

**Dr. Bond:** I am trying to estimate five miles. Yes, I would imagine that is quite possibly true, yes.

**Mr. Lawlor:** I am going to give you the McKinsey report, and I want to run through some of the sections under the special area here that has to do with Lakeshore only. It is the L portion of the book.

**Dr. Bond:** Are you talking about page L-2?

**Mr. Lawlor:** Beginning with L-2, yes. Just to get the picture, it appears in that third area—they are talking about the catchment population growth, and this is with 20 per cent taken off to be reallocated to Queen Street—that the projection from 1976 to 1978 is an increase of 37 per cent. That is not only what McKinsey says, but I take it that you give credence to that?

**Dr. Bond:** It is an amazing figure, but if you travel out to Mississauga, Brampton and those areas it is just frightening the development that is going on there, so I could believe that is somewhat within the range.

**Mr. Lawlor:** All right. Jump down to the next level, over on the left-hand side, where it says, "Despite increased admissions," and then down below, the Lakeshore admissions increasing 87 per cent from 1965 to 1976; is that correct?

**Dr. Bond:** Yes, that is correct.

**Mr. Lawlor:** And the ratio of outpatients to inpatients on books is quite a remarkably different figure from the others, 4.8 per cent. Can you give some explanation of why there's that very large outpatient ratio over against inpatients at this hospital?

**Dr. Bond:** I think it is due to our partial hospitalization programs, which really sort of emptied the hospital to a large extent.

**Mr. Lawlor:** It makes it easier for you to release patients and receive them back for continued treatment at a substantially reduced cost to the public?

**Dr. Bond:** I don't know what the final costing would be; I am not a—

**Mr. Lawlor:** Not an actuary.

**Dr. Bond:** No. I have heard arguments that it may not be such a great difference; in fact, it might be cheaper for custodial care in the

long run, but that has to be weighed against the humanity factors.

**Mr. Lawlor:** In other words, living in the community and with families and in close proximity.

**Dr. Bond:** You can't just take chronic patients out and just dump them in the community; you have to take a whole lot of things out there for them. You have to have workshops, you have to have recreational facilities, social workers, heaven knows what. So a fair proportion of our staff are actually not working in the hospital at all, they are working in the community, so the hospital diffuses itself into the surrounding area.  
[5:15]

**Mr. Lawlor:** Looking down at the short-term length of stay, it would appear highly credible to your hospital that you have the lowest days of stay. I am looking at 1976, when it was 34. It is the same as at Queen Street, but Whitby is 54. When you go over to 1977, you are at 32 over against 40 and 62. All I wish to do on that question is give you praise. Would that indicate efficiency of staff, intensity of care, or what would you attribute it to?

**Dr. Bond:** I would like to attribute it to that, thank you for the compliment, I think to be fair you have to realize that hospitals like Whitby also have some units of retarded people in chronic care, and geriatric patients. This does prolong your average length of stay.

**Mr. Lawlor:** Would you turn over to the next page, L-3, and let me read this into the record, on patient population:

"The current situation of approximately 300 daily inpatients in the hospital should continue and the 300 outpatients being treated on any given day should increase in number by about 30 per cent over the next 10 years."

It goes on:

"Resources: In line with changing inpatient demands, the number of beds required should decline from the current 330 beds set up to about 270 by 1981, and then grow with population to reach 315 beds by 1987. Similarly, total staff, both therapeutic and support staff, should decline from the current level of 650 to approximately 565 in 1981, and then grow to approximately 680 by 1987."

Those figures are all known to you and acceded to by you?

**Dr. Bond:** These were projections that were considered valid at the time.

**Mr. Lawlor:** Have you any comment to make in a professional way with respect to

a hospital that will have 4,000 outpatients per annum on its roster?

**Dr. Bond:** I think actually our number of outpatients right now is about 1,400.

**Mr. Lawlor:** I am talking about 4,000 at Queen Street, if this hospital is closed.

**Dr. Bond:** Oh, you are not talking about Lakeshore?

**Mr. Lawlor:** No.

**Dr. Bond:** Could you rephrase the question?

**Mr. Lawlor:** On the figures given here, there will be 4,000 outpatients at Queen Street within a very short period—three or four years at the most. Have you any comment to make upon that very large outpatient load?

**Dr. Bond:** I don't think it is very desirable. Psychiatric hospitals do, if I may use an objectionable term, form ghettos around them of chronic patients who depend on the hospital and cannot be located very far away from it. So I guess it means a further saturation of the community in that area. Housing is a difficult problem for these people.

**Mr. Lawlor:** I will come back to these statistics and sheets in a few moments. I would like your comment, as objectively and fairly as you can, with respect to the impact of this closing on other hospitals in the vicinity, on the police and on the public health services being provided. Start with the other hospitals, general hospitals.

**Dr. Bond:** I suppose in answering that I would be influenced somewhat by comments they have made themselves. There should be some services set up in that area to offset the closure of Lakeshore. I think the main problem will be with the patient who has to be hospitalized in an emergency—the police case types; they, I think, are the major problem. I guess it means further for the police to go to take them to Queen Street.

**Mr. Lawlor:** Let's discuss that for a moment. The whole of chapter two of McKinsey is a long exposition of the utilization of psychiatric hospitals on one side, and the range and type of patients they accommodate over against general hospitals. I think it comes down fairly conclusively saying they perform completely different functions. The short-term and the not-too-serious patients can be accommodated at these other hospitals, but the very large number of longer-term patients and psychotic ones cannot be and will have to be referred to a unit. You get very extensive referrals at the present time from the surrounding hospitals, isn't that right?

**Dr. Bond:** We did until we lost part of our catchment area.

**Mr. Lawlor:** Until they cut you off.

I'm going to ask a difficult question of you, partly based upon a statement made by Dr. Warren, who is the medical officer of health for the borough of Etobicoke. Let me read this to you: "Ideally there should be outreach mental clinics providing assessment, drugs, individual counselling, vocational counselling, associated with day care and workshops. Such clinics could operate from general hospitals or from the Queen Street Mental Health Centre.

"We have some reservations about the latter—about Queen Street—inasmuch as there is a very significant difference in philosophy on how to provide mental health services between Queen Street Mental Health Centre and the Lakeshore Psychiatric Hospital. Even if Queen Street accepts such a difference for the time being, we have no assurance this will not be subsequently changed and further increase the concerns and anxieties of present Lakeshore staff and ourselves."

He goes on in that vein.

All the reports coming to us are that Queen Street is more difficult of access, that it has somehow different criteria, that it's tougher to get people into it, that the police much prefer to bring people to Lakeshore as you're more open about it and more accepting. By deliberate intent they steer away from Queen Street. Are my statements aggravating or are they true?

**Dr. Bond:** I have heard the same complaints.

**Mr. Lawlor:** Is there a different approach to mentally ill people in both institutions?

**Dr. Bond:** I don't know that I could really say that. I don't know enough about the internal operations of the Queen Street Mental Health Centre. I think we're really talking about the screening process or referrals.

**Mr. Lawlor:** Assessment, yes.

**Dr. Bond:** I think our hospital has always been more accepting. That's what we hear; naturally we aren't in the business of trying to get patients into Queen Street, we're not involved in that. It seems they have stricter criteria, perhaps, I suppose.

**Mr. Lawlor:** Do you receive patients at your hospital who have been to Queen Street and have been turned aside?

**Dr. Bond:** That has happened, yes

**Mr. Lawlor:** Let me go off onto something pleasant before I come back on mere statistics. Your grounds, those extensive and



pleasant grounds with the lake, the water et cetera—I know it's an intangible factor in mental health, but is that a therapeutic environment for ill people?

**Dr. Bond:** I think it's an asset, yes.

**Mr. Lawlor:** Is it an asset to be weighed seriously in seeking to assess this whole matter?

**Dr. Bond:** On that I'm doubtful; I don't know. Despite these beautiful grounds it's surprising how little the patients use them. They still seem to be attracted to the street and the shops and the rest of it. I guess we're gregarious animals, we don't seek solitude.

**Mr. Lawlor:** Dr. Warren goes on—and I think again it should be part of the record—with respect to his role and his liaison with your hospital: "Our statistics in regard to the numbers of public health nursing contacts with persons diagnosed 'mental health problems' have increased from 3,551 in 1976 to 5,239 in 1978, during a period when our total population remained much the same, that is 293,000. Unfortunately, we are unable to provide comparable statistics for earlier years because of changes in the keeping of such data. However, the problem as reflected in nursing activities has escalated from 1964 to 1974, more than 10-fold in proportion to the population increase. The increase of population between 1964 and 1974 was about 61 per cent. The increase of home visits to persons with mental health needs between 1964 and 1974 was almost 700 per cent."

He goes on: "It is extremely important that concrete action be taken immediately to ensure that the health teams created by Lakeshore Psychiatric Hospital remain intact and capable of delivering these services. In this particular situation, the credibility of the Ministry of Health is being severely taxed. It is unrealistic to assume that present Ministry of Health personnel can resolve these issues and carry on their other responsibilities."

Those are pretty cryptic and penetrating things to be said by the local medical officer of health. Have you any comment on that at all, and in a broader way on the public health nurses and your relationship with them in the Etobicoke area?

**Dr. Bond:** We've had a good liaison with them because of the policies of our director of nursing, who has always advanced their cause. She hired quite a lot of public health nurses for the hospital outpatient department. There has always been a close liaison, but it seems to be a need you can never

satisfy. Their case loads seem to increase year by year. I think this is a phenomenon of our western world right now. I don't know what the cause of it is. There is obviously far more domestic turmoil than we had in the past, unless it was hidden before.

**Mr. Lawlor:** I would think everyone had been reading Jean-Paul Sartre and had nausea.

Would you turn to page L-8 of these sheets? It gives the patient population. The daily census should be increased by similar proportions. In the case of the outpatients they show a 34 per cent increase from 1976—I suppose it's 1976; the next year is 1978—between the current and 1987. This is largely in the after-care area; this is the care provided through Lakeshore only. Over against that, the inpatient population is extremely small, only a one per cent increase. In other words, there is a levelling out anticipated with respect to it. It's not as though you're going to need a lot more beds or greater weight is going to fall on expanded hospital facilities. On the contrary, it's the outpatient load that is going to have to be met in this particular area. Isn't that what that would indicate to you?

**Dr. Bond:** I would read it that way, yes. [5:30]

**Mr. Lawlor:** Again, in terms of page L-10, as to staffing it indicates with respect to the therapeutic staff a current number of 340, growing in 1987 to 365. It is nothing monumental, the public treasury is not going to be overwhelmed should the body remain. In the case of support staff—and there is a long list of what this comprises—the current is 310 over against 315, five more in 1987. Since you had some involvement in bringing this role study into being, I take it you think these are pretty accurate figures.

**Dr. Bond:** I would think so. Obviously the community will expand their services to offset the hospital.

**Mr. Lawlor:** Mr. Chairman, I am interested in two things. The doctor may not be able to give it, I would like the minister to give it. I am looking for what expenditures have been made with respect to the past five years, in each of the years, with respect to these buildings; a question previously asked but not tied down.

Remember you and I used to meet some time ago, most pleasantly. On a previous putative closing of the hospital—about four or five years ago, maybe even longer ago, 1972 or so—they said they were going to switch the whole facility over to retardation, to re-



tarded children basically. That is still being mooted at the moment, have you heard anything about that?

**Dr. Bond:** What you are talking about in the past; I think it was about 1975 or 1976, wasn't it?

**Mr. Lawlor:** It could have been in there, yes.

**Dr. Bond:** There was a plan at that time, not to close the hospital but convert it to retardation. That was stopped for some reason.

**Mr. Lawlor:** My second question was—and I got them mixed up—I hear that rumour again today; do you?

**Dr. Bond:** I have heard vague rumours, but we hear rumours every day, all sorts of things. I don't know of any plan.

**Mr. Lawlor:** All I wanted was a slightly greater substance than the rumours I hear; the rumours you hear may be more important.

**Dr. Bond:** No, I'm sorry; we are usually the last recipients of the rumours.

**Mr. Lawlor:** I am going to be flippant for a moment; Dr. Bond, do you know that hospital is built on a gas well?

**Dr. Bond:** Yes.

**Mr. Lawlor:** Many years ago, when it was first built, there was natural gas under the land and they were able to heat, I believe, and certainly to light, the whole building from the wells on the premises.

**Dr. Bond:** Yes, that is historically correct. Actually the first building was the alcoholic unit, cottage C. I gather that in digging the foundations they hit a seam of natural gas, so they capped it. Then when they completed the building—the administration building—they used it for lighting purposes; not for the whole hospital, just the administrative building, until about 1909 or 1910 when they switched to electricity. But the seam ran out about then.

**Mr. Lawlor:** Oh, did it? I thought we had a bonanza.

**Dr. Bond:** We might have. An oil company did seek permission to drill, but the Ministry of Health wouldn't let them.

**Mr. Conway:** Surely reason to nationalize.

**Mr. Lawlor:** There might be oil just offshore.

**Mr. Conway:** Test of your radicalism, Lawlor.

**Mr. Lawlor:** Don't give it away.

I would like to get those expenditures on the five years, I want to make a note of that. Is the building unsafe?

**Dr. Bond:** From what point of view?

**Mr. Lawlor:** I don't know; I just asked a general question. Is it a fire hazard?

**Dr. Bond:** In my opinion it isn't. The last fire was a deliberate act of arson and a person has been charged with murder. I think an arsonist could burn us up right here.

**Mr. Lawlor:** We almost had it the other day, the bomb scare.

**Mr. Conway:** Perhaps a more interesting point is whether or not the facility would stand a fire examination.

**Mr. Lawlor:** Dr. Bond, what is your future?

**Dr. Bond:** I plan to take this offer to go to Whitby.

**Mr. Lawlor:** Thank you very much.

**Mr. Duktza:** Dr. Bond, you have administrative responsibility, of course, but a much more important role you play as a medical director is supervising the programs, designing the programs and presumably making sure that the psychiatric needs of the Lakeshore area are met. Some of my questions will be very direct and some may be more general in terms of your feeling about what kind of model one uses in the modern day to deliver up-to-date psychiatric care.

First I would like to ask a couple of questions which Mr. McMullen left for you to answer. Could you tell me what is the present state of the Lakeshore Psychiatric Hospital relationship with the University of Waterloo and what will happen to it?

**Dr. Bond:** There was an affiliation between the psychology department and Waterloo University. It wasn't cross-appointments. There was the weekly consultant—

**Mr. Duktza:** I can think of two people who used to have cross-appointments; Dr. Steffy used to.

**Dr. Bond:** Yes, I'm sorry; to that extent, yes. Dr. Steffy only, at the moment, I think; and of course students doing field work. I was talking to Dr. Steffy and they understand that this all comes to an end this summer.

**Mr. Duktza:** This is a program which started many years ago and was much valued. Would you agree it had been rather valuable in terms of research and innovation and provision of services?

**Dr. Bond:** Yes, it has been quite valuable. Dr. Steffy's services have been very good.

**Mr. Duktza:** How many students have there been?

**Dr. Bond:** I couldn't tell you exactly.

**Mr. Duktza:** How many would you have right now?

**Dr. Bond:** I don't even know that we have any right now. Probably two to six, I would think, at any one time.

**Mr. Duksza:** It is usually on the level of post-MA, isn't it; it is a graduate program?

**Dr. Bond:** Yes.

**Mr. Duksza:** Have you ever had other types of involvement with any other universities?

**Dr. Bond:** Yes; we used to have a student placement with the U of T. Social work had a similar arrangement. Really most of the services except medicine—

**Mr. Duksza:** Had this type of thing?

**Dr. Bond:** Yes.

**Mr. Duksza:** In the strict sense, universities would have to make this type of arrangement with Whitby or Queen Street. The most major loss would be in terms of direct provision of services, we are probably in agreement on that.

I asked Mr. McMullen about his role in the McKinsey role study. He said that not only was he involved directly, but a number of people were involved with direct input into the recommendations of the McKinsey role study. Mr. Lawlor already asked you a number of questions. Was the medical staff very much involved in the recommendations?

**Dr. Bond:** Yes, they were involved. The McKinsey people were very thorough. They spent weeks there at all levels. They didn't just talk to department heads or medical staff. They pretty well cross-examined from the grass roots. Even nursing staff on the wards were talked to.

**Mr. Duksza:** One of the things I am concerned to establish is that the role study is not just something the outside agency picks up and develops on its own. It was developed through the thinking of the three hospitals directly involved. It reflects the basic, orthodox, modern approach to the safe delivery of psychiatric services by the total staff and the communities of the three hospitals. Would you say I am correct in saying that?

**Dr. Bond:** I don't know about this word "orthodox."

**Mr. Duksza:** Oh no, not orthodox, I'm sorry.

**Dr. Bond:** We are not afraid of the word, but we like to feel we were innovative.

**Mr. Duksza:** By "orthodox" I mean there are certain things which are now accepted in terms of the delivery of psychiatric services. The minister himself forever refers to community-based psychiatric services. I was struck by what Mr. Leluk was asking you and

your answer that you believe very strongly in community-based psychiatric services. Would you say it is possible at our present state of knowledge of psychiatry that we could in effect deliver most, if not all, psychiatric services in the community; or that at our present state of knowledge we now know there are exceptions?

**Dr. Bond:** We ought to be able to deliver the vast majority of services in the community, yes; but there will always be, of course, the special problems—the alcoholic, the brain-damaged, the dangerous people, the psychotic retardate; there will always be these individuals. This is what a psychiatric hospital is designed for and it should be complementary. I think it is rather unfortunate that we keep thinking in terms of a general hospital versus a psychiatric hospital. They should be complementary to each other, not in conflict.

**Mr. Duksza:** No, I accept that. In effect, as you say, they have different roles but they are complementary.

You also mentioned that the police are involved in mediating—not in direct admission but in bringing patients to the hospital. Could you tell me what percentage of patients involve the police one way or another?

**Dr. Bond:** At a rough guess I would say as high as one in three maybe.

**Mr. Duksza:** That's the figure I know they use at Queen Street, one in three. What would be the figure in the average psychiatric unit of a general hospital?

**Dr. Bond:** It would be much less.

**Mr. Duksza:** Infinitesimally less, am I right?

**Dr. Bond:** The police of course take a lot of patients to the emergency departments of general hospitals where they are seen and then sent on to us. When I said police involvement, I didn't mean necessarily they were police bringing people under that section of the mental health act but simply offering conveyance.

**Mr. Duksza:** Yes, I realize that; some are brought directly by the police, some of course are conveyed; that's why I say "mediate" in that sense.

Are we going to finish right now?

**Mr. Chairman:** I understand we have a vote in five minutes. I have Mr. Sweeney and Mr. McMullen on my list.

**Mr. Duksza:** I have not finished.

**Mr. Chairman:** Would you want Dr. Bond to come back or can we finish immediately after the vote?

**Mr. Duksza:** I don't think I could finish in that time. I think there is no point in going

on, really. The mood has changed, the ambience has changed, which makes it quite difficult in terms of questions; but I do have a number of questions. So what would you suggest, Mr. Chairman?

**Mr. Chairman:** I would want some direction as to whether or not you want all of the people listed to come back at another date. For instance I am wondering if Mr. Bateman of the Ontario fire marshal's office, or Inspector Ross Taylor of the Etobicoke Fire Department should be asked to come back. Are there points the committee wishes to clear up that could be cleared up quickly? What do you wish?

**Mr. Duksza:** Mr. Chairman, not only is there Mr. Bateman, but Mr. Suttis from the maintenance department and Mr. Barnes who is responsible for fire safety. All those would have to be questioned because one of the main reasons brought in by the minister to close the Lakeshore is because it is unsafe. Everyone so far has said they don't think so. So it is essential for us to establish that at this point. It will take time, I don't think we could just do it in two minutes.

**Mr. Chairman:** No, no.

**Mr. Duksza:** Mr. Conway himself will have a number of questions.

**Mr. Chairman:** So you want all of the people, including Mr. Bateman and Mr. Taylor, to come back then?

**Mr. Duksza:** I would suggest we do it tomorrow and we postpone the Queen Street Mental Health Centre presentations.

**Mr. Chairman:** I think that would cause some problems. We have scheduled the people for tomorrow and I am wondering if the committee would agree to leave it with

the chair and the clerk's office to reschedule the people whom we have not heard today.

**Mr. Duksza:** Oh yes.

**Mr. Chairman:** I must apologize for the inconvenience to those people.

**Mr. Conway:** I am wondering about the continuity. I recognize the problems, but it seems to me that—

**Mr. Duksza:** Above all, I would like to hear Dr. Bond, because I have not even started to ask him questions in a full manner.

**Mr. Lawlor:** Mr. Chairman, could I make a suggestion? I suggest that people concerned with the fire and maintenance, which concerns Mr. Ernie Barnes, Mr. Bateman, and Mr. Taylor, be scheduled at some future day. I think we should continue the list tomorrow otherwise, and try to get on. We have a longer day tomorrow, starting at 2 p.m.

**Mr. Chairman:** All right. Would the committee agree to this: We start at 2 p.m. tomorrow. Would the committee agree to go until 6 p.m. and in that way I think we could accommodate everyone?

**Mr. Duksza:** Fine with me. So who do we start with first thing tomorrow?

**Mr. Chairman:** We'll start with Dr. Bond or Dr. Lynes. We could start earlier tomorrow. We could start at 1 o'clock and go until 6. I don't mind, I'm here anyway. I just want to try to accommodate everyone.

**Mr. Duksza:** One o'clock, and we start with Dr. Bond, if he's free.

**Mr. Chairman:** If we start at one o'clock we'll start with Dr. Bond. Is that agreeable? Agreed.

The committee adjourned at 5:45 p.m.



### SPEAKERS IN THIS ISSUE

---

Conway, S. (Renfrew North L)  
Dukszta, J. (Parkdale NDP)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Jones, T. (Mississauga North PC)  
Lawlor, P. D. (Lakeshore NDP)  
Leluk, N. G. (York West PC)  
McClellan, R. (Bellwoods NDP)  
Pope, A. (Cochrane South PC)  
Rowe, R. D. (Northumberland PC)  
Sweeney, J. (Kitchener-Wilmot L)

**From Lakeshore Psychiatric Hospital:**

Bond, Dr. I., Medical Director  
McMullen, J., Administrator



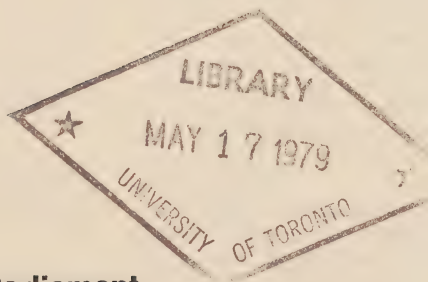
No. S-7

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Wednesday, April 25, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.



# LEGISLATURE OF ONTARIO

WEDNESDAY, APRIL 25, 1979

The committee met at 1:05 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Chairman:** We'll convene the meeting this afternoon. When we adjourned last night Dr. Bond was with us; so, Dr. Bond, if you wouldn't mind joining us again. Mr. Duksza, I believe you hadn't completed.

**Mr. McClellan:** Just before we resume the discussion, is there anybody from the ministry who can give us a quick, capsule description of the two pieces of material that were provided to the committee this afternoon?

**Clerk of the Committee:** Dr. Surplis was here, and Mr. Boddington; I'll see if they are outside.

**Mr. McClellan:** I don't want to hold things up. Maybe as the ministry people rematerialize—

Interjection.

**Mr. Chairman:** Perhaps we could continue with Dr. Bond; we'll get back to that information. Mr. Duksza?

**Mr. Duksza:** If I am correct, I was in the midst of asking you, Dr. Bond, about your role in McKinsey. If I am correct, that is where we stopped. Could you try to summarize the way your staff and other people feel about McKinsey being the most creditable alternative being presented by that committee as the solution for a number of years of the psychiatric needs of the Metro area?

**Dr. Bond:** From my contact with the staff, I'd say it has the support of all branches of the staff. I've never heard a member of the staff criticize it.

**Mr. Duksza:** A number of people in the hospital—I know it's a bit of a repetition but I think we should get back to it—a number of significant articulators in the hospital worked on the study, if I am correct.

**Dr. Bond:** That's right.

**Mr. Duksza:** Maybe you could tell us some of the basic assumptions—and that will be the next series of questions I'll have of you—some of the basic assumptions which

underlie the recommendations of the total professional staff of those three hospitals as articulated in the McKinsey report. You've already given us a hint in terms of division, role differentiation between the psychiatric units, community-based services and the provincial psychiatric hospitals. I wonder if you will summarize, in effect, as volubly as you feel inclined, these basic assumptions.

**Dr. Bond:** I think their basic tenets were the projected population growth in the west end of Toronto—and it wasn't confined to the Lakeshore catchment area; it was a study of the greater Metro needs—and the observation that the psychiatric hospitals had a very valid complementary role with the general hospital psychiatric units. I think those were the main tenets on which they based their recommendations.

**Mr. Duksza:** Is there acceptance on your part, Dr. Bond, of the fact that the provincial psychiatric hospitals deliver a different type of care to a different target group?

**Dr. Bond:** Oh yes, very much so. The psychiatric hospitals in a sense serve the most disadvantaged people in our community. The people who come to the psychiatric hospitals are, if I could use that word, "sicker"; they are probably much more ill. They tend to be chronic; they tend to have different diagnoses from those in the general hospitals. We handle very few psychoneuroses; we deal mainly with psychoses, brain damage, and to a much greater extent every year the explosive psychopathic personalities. Also there is a sex ratio: Far more men come to psychiatric hospitals than women and vice versa to the general hospitals.

**Mr. Duksza:** The staff ratio is also different. Provincial psychiatric hospitals have, I suspect—or do you know?—less staff to take care of the number of patients—

**Dr. Bond:** I think you'd have to break that down by disciplines. Probably there's more adequate nursing coverage in general hospital psychiatric units. But, of course, the psychiatric staffing of general hospitals is quite different; it's not done on a salaried basis, but on an admitting privilege, private practice type of operation. So it's rather hard to compare them. But, as I say, on the whole

psychiatric hospitals do not attract sufficient professional staff.

**Mr. Duksza:** So that the delivery of the psychiatric service in a provincial psychiatric hospital is largely by health professionals but they tend to be more nursing assistants and less psychiatrists and psychologists I suspect.

**Dr. Bond:** Again, that would depend where the hospital was. If you are situated in Metro you don't really have difficulty in hiring professional staff if you have the complement and budget, but if you go outside Metro you get a very serious shortage of professional staff.

**Mr. Duksza:** Would you hazard a guess, or maybe you have some comparative data in terms of cost per day for psychiatric service in a general hospital as compared with your hospital?

**Dr. Bond:** I think our recent per diem rate was in the order of \$130 per day; something in that order.

**Mr. Duksza:** In your hospital?

**Dr. Bond:** In our hospital, yes, and ours had the highest—

**Mr. Duksza:** I didn't realize that.

**Dr. Bond:** I think Lakeshore probably had one of the highest per diem rates of all the psychiatric hospitals because we were able to hire more professional staff of a higher income bracket than some of the more remote hospitals. I don't know what the per diem rate is in the general hospitals, but of course it would be higher than that, I think.

**Mr. Duksza:** I know it's much higher, but I didn't realize that your per diem rate was as high as that.

**Dr. Bond:** It has gone up very rapidly in the last year or so from about \$70-something a day to \$130.

**Mr. Duksza:** I see. When you calculate that, do you include your extensive outpatient and community contacts; or are we talking specifically about beds?

**Dr. Bond:** Perhaps one of my colleagues could answer that better. I don't think so; I think this is inpatient costs.

**Mr. Duksza:** One of the penalties I suppose of calculating it per diem the way you have said it is that the more you discharge, the more expensive the treatment per bed becomes, because it's not taking into account the very extensive ambulatory preparation. I know that if you have 10 people in day care which is on the ward this is not taken into account and the cost of the beds keeps on going up while you're delivering your larger service; I'm almost certain of that.

**Dr. Bond:** That is correct, yes.

**Mr. Duksza:** But nevertheless, you're entirely right that the costs in a psychiatric unit in a general hospital are higher not only per diem per bed but also because the staff, and by that I mean psychiatric staff, is on a fee for service. I would say that works out as a ratio of as much as one to two, that it's twice as expensive on that level than the way you have it in your hospital. Additionally, of course, a lot of treatment is given in the psychiatric hospitals by a non-medical staff, which may be all for the better in the area which is hardly medical at all but more in the problems of living.

From this I'd just like to jump to your own feelings and your own ideas of what an appropriate psychiatric service is. You are, after all, responsible for devising the programs. We'll start with a series of definite questions. What do you think is an ideal size —by "ideal" I mean what is an accepted size —of a psychiatric hospital according to both recent literature and your own experience?

**Dr. Bond:** I would say a bed count of 300 to 350 is about the optimum-size probably.

**Mr. Duksza:** That I think fits very precisely with what has been recommended by the joint commission, which is many years back in the Tyhurst report and almost any work done since—350. Would you care to tell the committee why it is considered that 350 is about an appropriate size and not 800 or 900?

**Dr. Bond:** I think mainly because the larger an institution gets, the more impersonal it gets. The individual tends to get lost in numbers. I think there are economic factors too and that would deploy against a hospital being much smaller. If you had hospitals with fewer than 300 beds, you'd probably find it much more expensive to have three small hospitals than, say, one medium-sized one.

[1:15]

I think the problem with the large institutions is mainly that they become rather huge, impersonal institutions where the staff very often lose their camaraderie, esprit de corps or whatever it is, and you end up by getting balkanization. Each unit then becomes a discrete hospital of its own, so to speak. You get territorial problems and each unit behaves as though it were an institution in itself. You do not get the cohesion and co-operation you get where the staff all know each other through working in a smaller place.

**Mr. Conway:** Dr. Bond, you have indicated that 300 to 350 beds is an optimal figure. It has been suggested, paying some attention to budgetary constraints within the Ontario



jurisdiction at present, that if the government could not afford to proceed with the \$28 million expenditure that is estimated would be required to meet the McKinsey recommendation, perhaps a much smaller staged reconstruction of 100 to 150 beds would be in order. How would you respond to that?

**Dr. Bond:** I am talking privately now of course, but I suppose half a cake is better than none from our point of view. What you are asking is, is it advisable to set up a small hospital of 150 beds? It might be so if that hospital were a purely specialized one and not dealing with the general psychiatric admissions of a large catchment area.

**Mr. Conway:** But if a decision were to be made in respect of rebuilding Lakeshore, you would certainly privately recommend 300 beds roughly?

**Dr. Bond:** Yes, I would.

**Mr. Duszta:** You are well aware, Dr. Bond, because you had in fact started your psychiatric work many years ago—just a few years before mine, actually—that the people in the psychiatric hospitals in the past were preoccupied, and rightly so, with the effect the large institutions have on individuals. I think there has been a concept developed called “institutionalization” which said that ultimately, if people stayed long enough in a psychiatric hospital, their symptoms were no longer at all related to what brought them in originally, but entirely due to the fact they were in large institutions.

I know we don't talk about this as much, but the whole question of getting people out into the community as fast as possible after a short stay is in effect to prevent this type of deterioration of personality, which can occur if you incarcerate anyone. Would you say we are taking a risk with combining the two hospitals into a very large institution as it is proposed—more than proposed—right now? Are we taking a risk of reintroducing the dangers of institutionalization with the patients you serve at the Queen Street Mental Health Centre?

**Dr. Bond:** It is possible but I doubt it. I think after the disappearance of Lakeshore, Queen Street Mental Health Centre will have a rather staggering load of admissions, in which case there is an impetus to get clear beds. In other words, for hospitalization to occur—this phenomenon we call “hospitalization”—you cannot do that if there are big demands on your beds. The admission rate would have to be rather sparse or sluggish.

We sort of prided ourselves at Lakeshore that we were avoiding hospitalization by having very rapid rehabilitative programs

so that we were able to process the 2,500 through a small number of beds—331 beds. Queen Street will have the same problem, because although they will only have 600-and-something beds, presumably they are going to have double the admission rate of before, unless some demographic things happen that we have not foreseen. Our admission rate before this happened was always larger than Queen Street's, so in effect the admission rate should double. I think there will be tremendous pressure on the staff of that hospital to get the patients out as quickly as possible.

**Mr. Duszta:** Yes, of course, it goes without saying there will be enormous pressure, but when there is such enormous pressure, sometimes the effect it has on the patient is to make the people stay longer because of inability of the staff to deal with the ever-increasing pressure from new admissions. You really need some time to assess it. In effect what has happened—you have worked in a hospital before—is people simply put up extra beds and the population goes up. You have been in a situation and I have been in a situation where we just got an extra bed, and before you know it you have overcrowding. Is that not one of the dangers of combining two large institutions into one?

**Dr. Bond:** Yes, I was assuming, however, that Queen Street would have a commensurate increase in staff to handle this new input. If that does not happen and if the staff gets overwhelmed, that could happen. Patients don't move; they sit.

**Mr. Duszta:** The commensurate increase actually is misleading because they are not transferring a significant percentage of support staff. They are transferring a major percentage of the professional staff, so in effect the ratio, which is calculated over all staff and patients, would go down. It would have that effect. People who work as support staff are very essential to keep the thing going, because if that's not going then the whole therapeutic process is endangered by the fact that there is not enough support staff. Am I not right, looking at our own experience in the past?

**Dr. Bond:** I don't feel very confident to answer that because I was not involved in any of the planning. It is really Queen Street's mandate to decide what it needs from the Lakeshore staff. As far as I know, all the nurses, a large proportion of the other clinical staff and the support staff are going. My understanding is that Queen Street is more mechanized in the sense that it has modern electrically controlled carts



and things of that nature so that it doesn't need so many support staff. But really I think someone from Queen Street should answer that.

**Mr. Duksza:** Yes, I do intend actually to ask those questions when we move to that point, because it is important to know whether an institution like Queen Street is ready or able to accept this new load and what it will do to its own programs. Let me move for the next couple of questions in a sense to maybe the nebulous network of community-based services that the hospital provides. What is your own feeling, once the hospital moves and a certain disruption occurs in the linkages, about what will happen to the extensive chronic population which is now kept in the community in various institutions, homes and boarding homes—the backwoods of the community in effect? What will happen to that group?

**Dr. Bond:** I understood that the chronic care wards are going to Queen Street.

**Mr. Duksza:** I did not mean the inpatients. What I am asking is where do all those thousands of people go? None of them was recovered and none of them was rehabilitated or retrained. A significant percentage of them were put in the halfway homes and in special care in boarding homes. Many of them live around the hospital in my area and in Dovercourt and other places, often without supervision, without retraining, without rehabilitation, without supervised industrial programs and without sheltered workshops.

There is a large population. Some still have contact with the hospital, whether it is for medication or for talking. What will happen to that group if the immediate centre is removed and they have to relate to a completely new group of people at Queen Street? Do you think that we are creating a new pressure for admission from that group by severing the basic community-hospital linkage which keeps those people out of inpatient care?

**Dr. Bond:** It is certainly going to be interesting to see just what is going to happen. I am not sure what is going to happen to those people. I have always felt that most of these chronic care outpatients, those served by outreach programs, really do depend on a parent hospital as a base which nourishes these programs. I believe the ministry has some alternative plans to continue these programs out there in the west end. I do not know what the final plan is. I presume it will be to some extent based on the local general hospitals. I am

not sure how many of these the general hospitals can pick up.

**Mr. Duksza:** What is your own impression? How many of those can general hospitals pick up? Have they been able to do this before or in effect have they not always rejected this whole group of long-term patients in the community?

**Dr. Bond:** I don't know that they're unable to do it—

**Mr. Duksza:** Don't want to, you mean?

**Dr. Bond:** —but they didn't want to withdraw. I should imagine, large infusions of money and staff.

**Mr. Duksza:** The money which is now spent on keeping Lakeshore going, you mean. Where is all the fantastic saving?

**Dr. Bond:** I don't know where the money comes from.

**Mr. Duksza:** Would you say it would be more expensive, in effect, to shift the care for the long-term patients in the community to the general hospitals than to keep them in the Lakeshore Psychiatric Hospital?

**Dr. Bond:** In my opinion it would be more expensive. It would be cheaper to keep them in the Lakeshore Hospital.

**Mr. Duksza:** That's very interesting, because the minister's whole intent in this exercise is presumably to save money, presumably also to save money at the cost of people who are disenfranchised in some sense and who are the responsibility of the professionals. What are your worst fears of what will happen to that whole network of support for the long-term patients if the hospital is cancelled?

**Dr. Bond:** My fears, I think, would be for this helpless section of the community, the chronic disadvantaged type patients who are unwelcome, really, anywhere except in the psychiatric hospital. My other concern would be for Queen Street's added burden and the numbers they would have to care for, because some of them might drift down into the Queen Street area. If one hospital goes they tend to look for another one; they'll simply drift.

**Mr. Duksza:** How big a number are we talking, in your opinion?

**Dr. Bond:** We have, I believe, about 1,400 on our books. Some are managing on their own, without being actually on our books so to speak. I suppose we might be thinking about a couple of thousand people.

**Mr. Duksza:** It would be an immense burden.

I would like to ask a couple of questions on a more conceptual basis. It has been stated

repeatedly that this move to abolish psychiatric hospitals is a forward movement, the community psychiatry movement has been started and ultimately we will end up with abolition of the psychiatric hospitals. There has, of course, been a contrary movement among the professionals who realize it cannot be done. I was wondering whether you could share with the committee some of your feelings on the present state of the community psychiatry approach, the move to abolish the psychiatric hospitals, and whether there will always be a role for psychiatric hospitals like yours?

**Dr. Bond:** I suppose we have the example of the United States. Several states there rather zealously started closing down state hospitals one after the other, without any preparation, really, for very many community services to pick them up. Large numbers of former patients ended up as derelicts and problems to police and so on.

I think there has been a slight move back to keeping some of the state hospitals open but modifying them in size. I hope we don't make the same mistake.

I think the concept of community psychiatry is a very valid one. I think to argue against it would be like arguing against motherhood. Obviously, as many patients as possible should be handled outside of the psychiatric hospitals, if for no other reason than this stigma which always seems to get attached to public hospitals. But I think you can swing too far. I think there comes a point when you've reached your hard core.

There is a percentage of patients who can't live in the community; or if they do they suffer, they're miserable there. Therefore, I think just as we will always have—perhaps I shouldn't say that as it's a rather poor analogy; I was going to say we shall always have prisons, I suppose I shouldn't say that. However, we will always need residential facilities, institutions, call them what you will. We call them psychiatric hospitals now, but 100 years ago in England they were called workhouses. I think society has a need for these institutions, although their role is much more limited now than it was in the past.

On the other hand, money should be spent on them, they should be modern and comfortable. Patients shouldn't have to put up with physical conditions that are not tolerated in other hospitals.

**Mr. Duksza:** Let's say Lakeshore is in fact abolished and everyone is moved to Queen Street. Do you think within 10 years we may have to rebuild a hospital, either in Peel or Halton, or even on Lakeshore grounds, to deal with this particular problem?

[1:30]

**Dr. Bond:** Sort of crystal-gazing, I wouldn't be surprised if that does happen when we have another city out there; the projected growth there is so enormous. It may be a regional hospital rather than a government-operated psychiatric hospital.

**Mr. Duksza:** It doesn't really matter what kind of a solution—

**Dr. Bond:** Some sort of regional hospital may become necessary in time, but that's simply a projection.

**Mr. Duksza:** Yes, but that's a projection which is shared also by the McKinsey report. I don't know how one operates except to take into account what a group of professionals suggest will happen. So far, in many respects they have been quite correct. The joint commission said not only is that what we must do—this was in 1959—in terms of emptying the hospital, but that's what will happen and that's what we should proceed towards. The McKinsey report—and I'm not comparing them intellectually; McKinsey had far to go—is saying to us we cannot take a chance with closing the hospital because of this new flush of enthusiasm for saving money et cetera; that within 10 years, with the growth of population and the changing needs of the local population, we may have to have a hospital like that to take care of them. This is a fact of life, and that's what this whole hearing is all about: to persuade the government and the minister not to think only one week ahead but in fact to think months ahead—although we would like to persuade him to think 10 years ahead—to provide not only better and more necessary needs for the psychiatric patients but also to think, "My God, what will happen in 10 years' time?" I think that's about all the questions I have of Dr. Bond.

**Mr. McClellan:** Dr. Bond, I want just to focus on the one issue I raised with Mr. McMullen the other day, and that has to do with the continuation of the outpatient programs at Lakeshore.

When the minister made his statement in January, he included a statement—really a promise—that the outpatient mental health programs in operation at Lakeshore would continue uninterrupted, although administrative responsibility would transfer to Queen Street.

In February, the Minister of Health wrote to the board of volunteers for the behaviour therapy clinic. This letter is dated February 9 and is addressed to Mrs. Ann Breen; in it he said: "Please be advised that the recently



announced closure of Lakeshore Psychiatric Hospital will not affect the existence and activities of your behaviour therapy clinic. We fully intend to continue operation of all present outpatient services and indeed enhance them." He goes on to ask for their continued involvement in the program, which is being run largely with volunteers; it's a program run, I believe, with six paid staff, and the rest of the staff complement are volunteers.

I have been advised that four of the six staff at the behaviour therapy clinic have received layoff notices. Is that correct?

**Dr. Bond:** Yes, that's probably correct. I didn't come prepared with the actual figures. As far as I understand, the ministry has promised that this service will continue — there's no change in that — and the staff complement assigned to that unit, which is a very small complement, is unchanged. What has happened, of course, is that the full-time secretary of one of the four — or the three; whichever it was — was declared redundant. That doesn't mean they're not going to get a secretary, but when you get layoffs the union rules apply to seniority. That particular secretary, although she was highly valued by them, didn't have the seniority; so this business of bouncing takes place. It's a question of bouncing. It's unfortunate for the tranquil continuation of services, because somebody who has been trained and carefully nurtured, so to speak, suddenly has to give way to somebody else who is untrained in that particular field but has seniority in the civil service. I think the other people are probably part-time and of course all part-time employment ceases when you get closure of a hospital. Part-time people can be rehired, of course, once you get a budget going again.

**Mr. McClellan:** I think my information is that the medical secretary —

**Dr. Bond:** She was laid off, I think.

**Mr. McClellan:** —was laid off. The other paid staff who were laid off included a Mrs. Fullerton who was one of the two therapists —

**Dr. Bond:** She'd be part-time.

**Mr. McClellan:** —who was involved in teaching and supervising the core of volunteers who were actually running the program.

**Dr. Bond:** She started as a volunteer and I think she was put on part-time pay.

**Mr. McClellan:** I think she was three days a week, but she had been there a long time; and I gather from discussions I've had

that a pretty central role within the program is the teaching supervisor of the volunteers. The other two people who were laid off were the two paid senior therapists. The rest of the therapists are all volunteers. The two who were working part-time, each of them three days a week, were also laid off.

I understand what happens when there is a mass layoff at a hospital is that the seniority clause of the contract is invoked in order to provide a measure of equity to the people who are suffering the layoffs. But I have a copy of a letter from the clinic director, Dr. Neiger. It's a letter to Dr. Mech of the department of psychiatry at Peel Memorial Hospital. I just want to read from the fourth paragraph of the letter to Dr. Mech from Dr. Neiger: "What is, most unfortunately, completely overlooked is that the survival of the outpatient service is by no means assured. I do not presume to speak for other outpatient services, although I understand they have problems very similar to ours, but I do wish to thank you for highlighting our clinic as a vital resource to the counties of Peel, Halton, York and the west end of Metro, a resource which I feel is now being [has already been] destroyed."

It goes on to describe the staff cuts and then says: "If this or any of the other threatened cuts will come about, I can see no way of continuing this clinic."

My question to you is: Is Dr. Neiger's concern about the continued viability of the clinic justified?

**Dr. Bond:** Yes, indeed so. This also applies to the dialysis program and a lot of other things involving disruption of staff who are already trained and replacing them with others. I think I'd like to take this matter back to the management of the hospital, because I don't quite understand why the part-time people could not be rehired. They are not union employees, they are not a bargaining group. It is true that the bargaining group members do have to conform to the seniority clause, and I think what Dr. Neiger is deploring is that he has exceptional people he has trained over the years who now must go. It's most unfortunate, because that clinic is unique and there is no other out there that deals almost entirely with claustrophobic housewives.

**Mr. McClellan:** Yes.

**Dr. Bond:** They can get no help anywhere else.

**Mr. McClellan:** I gather the program has been providing an enormously successful



service—at a success rate of something in the order of 95 per cent—to housewives suffering from agoraphobia.

**Dr. Bond:** Yes, it has had excellent results; and it has been done at an extremely low cost because Dr. Neiger recruits and trains retired professionals usually, and volunteers. It was really an outstanding contribution, at very little public expense.

**Mr. McClellan:** Yes; and from both Dr. Neiger's testimony and from your comments today we can only conclude the continued existence of this service is highly problematic at this point. It is a question whether it will be able to survive the transition or not.

**Dr. Bond:** We hope it does survive.

**Mr. McClellan:** Dr. Neiger says parenthetically in his letter that other outpatient services have problems "very similar to ours." Can you enlighten the committee as to which of the other outpatient services have experienced a similar kind of loss in staff which threatens the viability of the program?

**Dr. Bond:** I guess he is referring to all the other outpatient services.

**Mr. McClellan:** All of them.

**Dr. Bond:** Probably, because there is the question of morale. It is an intangible thing, but it's very tangible when you come to produce services. When you close a hospital the staff morale zeroes down, there is no morale. Many members, of course, don't wait to be given new jobs; they seek jobs themselves.

**Mr. McClellan:** In fact, Dr. Neiger in the concluding portion of the letter is having a conversation with himself about whether it's possible for him to continue, despite the enormous success of the program.

**Dr. Bond:** I fear that may happen, yes.

**Mr. McClellan:** Just to conclude, I fear that it is highly problematic at best as to whether the outpatient services, which have been the heart and soul of the success of the Lakeshore Hospital, can survive the transition.

**Dr. Bond:** Are you asking for comment?

**Mr. McClellan:** Yes.

**Dr. Bond:** I don't know. I think they'll survive; but as to the quality I don't know. This is a new experience; I don't think a large psychiatric hospital has ever been closed before. There are small psychiatric hospitals in rural areas.

**Mr. McClellan:** Right.

**Dr. Bond:** I understand Dr. Lynes will be talking later and perhaps he can give more information on plans for the future, but we are not involved in the plans.

**Mr. McClellan:** Yes, I understand that completely.

**Mr. Pope:** I just wanted to ask a supplementary. I think you cleared it up but I am not sure.

You were saying you are not sure why the part-time staff, the three-days-a-week people, were let go?

**Dr. Bond:** Yes, I will have to consult with some of the members of the ministry and staff about this. It seemed to me if they were part-time people not involved in the bargaining group and the ministry had guaranteed the service would remain staffed, I don't know why these people would have been laid off or why they couldn't be rehired. As I say there might be a good reason for that; perhaps someone who is going to give evidence can tell us that.

**Mr. R. F. Johnston:** I won't keep you much longer; I know we've had you up here for quite a while.

Just following up from what Mr. McClellan has said, I wonder if you'd comment further on the outpatient side of things. We don't know the final outcome on a number of the programs that are there at the moment, but we can presume they may be taken over by general hospitals in the area or by community groups acting on their own; they may stay on the ground even after this period of changeover. But for a hospital which has had such a record—and we have a whole list here of all the firsts of Lakeshore, I don't think anybody is disputing the kinds of programs developed—is it not fair to say that disjoining these programs, taking them away from the common base of a psychiatric institution which has one emphasis, in some way jeopardizes the strength and the overall co-ordination of community services to the outpatient?

**Dr. Bond:** As I said before, in my opinion there is a danger of this happening, yes—

**Mr. R. F. Johnston:** Right.

**Dr. Bond:** —unless some very solid community base can be established; but I am not aware what the plans are for that.

[1:45]

**Mr. R. F. Johnston:** In your comments on the size of the inpatient hospital that is efficient to manage, in economic terms as well as human terms—the figure of about 350—is there a role that a psychiatric hospital plays in backup as a resource to these various outpatient groups and other groups in the community that are enhanced by the fact there is that inpatient load in that hospital and that there is a certain kind of staff

available? Would it be fair to say that might be missed if it was just left for the general hospital area?

**Dr. Bond:** Yes. You have to have an in-patient backup. Many of these outpatients relapse and need quick and brief re-hospitalization. If the general hospitals can pick up that function, that is fine; it doesn't matter where they go as long as the hospital can take them when they start to deteriorate, before they get too bad.

**Mr. R. F. Johnston:** Given the fact that our general hospitals are under a lot of pressure moneywise and staffwise, and have other considerations besides psychiatric, isn't there a real danger that the proper emphasis will not be there in the community?

**Dr. Bond:** I would think so, yes; unless those funds are specifically earmarked for just those services and not in any global budget. In any hospital, when you get a global budget you have a sort of a pecking order and psychiatry is usually right at the bottom of that.

**Mr. R. F. Johnston:** I think that is what I was looking for in that answer.

The other side of this matter that is of concern to me as somebody who has been involved in community projects to do with mental health, is that although we have a fairly elaborate system of community support laid out for us here, there is a remarkably high percentage of ex-patients of psychiatric hospitals in the community who are not getting support of any kind at this point; is that not true?

**Dr. Bond:** I fear that is probably true, yes.

**Mr. R. F. Johnston:** My concern is that a time when we are not sure about the comprehensiveness of any community-support program that we have to help people avoid re-entering psychiatric institutions on a long-term basis is a really bad time to take apart an institution which has developed one of the better infrastructures for this. We know there are large numbers of people who still are not being touched by that kind of network and who really could use more support and more concentration. I suggest it would be much better if there were one institution that had that area of concentration, rather than splitting it up all over the community; without any forethought before this decision was made, obviously, as the minister said to us, and that is very disturbing to me.

I want to ask you a point of information on something that has concerned me. In a lot of the projections that have been made on bed usage, I don't see any consideration

of the fact that over the last 10 years the usage of drugs and community support have enabled more and more people to be treated in the community. We have had that situation now for a number of years. Is there, in your opinion, a percentage number of individuals in the community at large who require psychiatric institutional care; a figure that is accepted by authorities in the field, that could be used as a benchmark for planning in the long run? In other words, are we now at a stage where we are not going to be able to reduce significantly the percentage of people who need to have institutional care? Are we at the benchmark now; and are the projections the McKinsey report puts out accurate in that they see the natural population growth requiring the beds that they laid out; or are we going to be able to have less people involved in institutional care?

**Dr. Bond:** That, of course, is controversial; one can only give an opinion. I should have added that a large number of mentally ill people in the community are not served by hospitals; they choose to reject that, which is their civil right. As long as they are not under the Mental Health Act, of course, it is not an offence to be mentally ill. Treatment is only mandatory if you are a danger to yourself or others. So when you ask how many are out there, there are large numbers of people out there who could benefit from treatment but choose not to do so. You have to remember that; in other words you just can't treat them all.

If I could go back to your question again, it was have we reached the point of estimating the number of hard core cases. I think we probably have, or I would think we are pretty near to it.

**Mr. R. F. Johnston:** Therefore you would say that the McKinsey projections, based on present occupancy rates as they were and population projections for the area of Mississauga and so on, are accurate as far as you are concerned?

**Dr. Bond:** They still make sense as far as I am concerned, subject to unknown demographic and social upheavals. Our admissions probably are influenced by unemployment and this sort of thing, or in wartime they tend to have not so many attempted suicides. People don't commit suicide during wartime, or very few do. These sorts of things might influence it, but if things continue as they are I think they are pretty valid assumptions.

**Mr. R. F. Johnston:** Those are all my questions.



**Mr. Chairman:** Thank you very much, Dr. Bond. You have been most helpful and I am sure the members appreciate your appearance here.

**Mr. McClellan** mentioned that perhaps someone from the ministry could assist with the figures that were provided. I am wondering if Dr. Surplis or Mr. Boddington could do that?

**Dr. Surplis:** There is no one here from the branch today. I am checking on a couple of things. We will come back to it, Mr. Chairman.

**Mr. Chairman:** Right, yes.

**Dr. Maharaj** is the next one. Did I pronounce that correctly, sir?

**Dr. Maharaj:** Yes.

**Mr. Chairman:** Okay. Have a chair, doctor.

**Dr. Maharaj** is the director of the alcoholic services unit, I believe, at Lakeshore.

**Dr. Maharaj:** I am, sir.

**Mr. Conway:** I have had the pleasure of visiting the unit of which you are the director. I wonder, doctor, could you indicate to us, just as a point of introduction, your experience at Lakeshore; what your unit consists of, and more generally whether or not you would care to offer some observations about the kinds of things that you have done at Lakeshore that are perhaps unique in that field of service?

**Dr. Maharaj:** I will take the opportunity of going back a bit just to tell you the history.

I started at Lakeshore in October 1974. They had just started an alcoholic program and had between 12 and 14 beds; as of now we have 47 beds. We started a program dealing primarily with problems of addiction; over the period of time since then we have done several things. We were the second centre in North America to use the antabuse implant, in 1975. We also had referrals from all sources. We had a 28-day inpatient program. We have had no specific catchment area.

As of January last year, we changed to a new technique, going onto partial hospitalization. That means a patient stays in for one week then spends three weeks as an outpatient. The patient stays from nine in the morning to nine at night. After completing the program the patient attends one night a week for a period of one year; and there is added help, such as individual therapy, family therapy, et cetera. This program is still continuing and is called the elective program. We still have no catchment area.

We have referrals from industries, hospitals, physicians, detox centres, agencies; we have referrals from everywhere.

The uniqueness of that part of the program is that it has been strongly considered for the 1979 American Psychiatric Association achievement award as a pilot project for the North American continent.

In November of last year, we started off the second phase of the program, called ASU II. ASU I is an elective program. ASU II is a program that we started, realizing there are a number of patients who normally go into psychiatric hospital or general hospital because of a problem of addiction. One has to question which came first, the chicken or the egg: was the person depressed before becoming an addict; or became an addict and then became depressed?

From November 15 to March 15, 236 patients who would normally be admitted to a psychiatric ward or a general hospital went into that part of the program. The average stay was 5.32 days. To date what we have really looked at is the sort of person who is not motivated by any treatment program. We have started treating them because we feel it is part of prophylaxis. In the long term these are people who have problems with alcoholism or addiction, or a combination of both, who might eventually finish off in general hospitals or psychiatric hospitals at a tremendous cost to the ministry. Hopefully we can abort this propagation of disease in some way now that this program has started. This program has gained a great deal of momentum so far.

We have not advertised this aspect of the program. Some people call it a detoxification program, which it is not, really. A detox centre merely gives empathy, Band-Aids the problem and sends the person out; that is all it really does. Here we are really trying to treat these people.

The elective program is also continuing. We have been involved a great deal in the community—in schools, industry, lectures—and we have had a number of students do field work in the program.

We have changed the name of the program. It is no longer called the alcoholic services program; now it is the addiction services program because 60 per cent of those being admitted have cross-addiction, that is alcohol and drug related problems. We have had to revamp the program to treat these people accordingly.

We felt these people had to be hospitalized to some extent. One might say that with alcohol the withdrawal is easier, but in drug addiction or the combination of



both it is absolutely impossible. All the literature in medical textbooks as postulated so far suggests it would be criminal to try to detoxify a drug addict on an outpatient basis. That is basically what the whole program is about.

**Mr. Conway:** What you are indicating then is that your program, relative to others in the field, has had a high degree of success.

**Dr. Maharaj:** It has.

**Mr. Conway:** It is cost efficient in respect of some of the alternatives you have mentioned.

**Dr. Maharaj:** Correct.

**Mr. Conway:** In our earlier conversation you indicated a very high degree of positive relationship with the community in the locale where the hospital is situated, which I understand to be a very important part of the program you are developing at Lakeshore. Could you indicate just how important it is to have that kind of immediate area with respect to your program?

**Dr. Maharaj:** It is tremendously important to my program, because you are looking at an individual from three aspects, physical and psychological as well as social. As far as the physical aspects are concerned, we have been blessed to have good general hospitals in the neighbourhood which have been very helpful in seeing outpatients whenever required for any form of medical or surgical consultation.

Socially, the agencies in the community have been absolutely excellent in trying to help us, along with the public health department, assist these people to find their way back into the community; for example in trying to find foster homes for them, because some of the situations they have come from are quite traumatic. Most of our patients, 90 per cent, have families, and the family life has been totally disrupted. We thought that in giving them the chance to stay with foster families, although they might have failed on the first shot they would have a second chance to get some idea or model of what a family should look like, to reintroduce them to the life-style.

We have had a lot of discussion with many community agencies, looking at some of the problems they face and the type of alcoholics they deal with. This has made it very easy for them to refer people to us very quickly, to look at the problems and deal with them immediately.

With the concept we have at Lakeshore no patient is on a waiting list. In other

words, if anybody in the community calls about an individual who is motivated and wants help immediately, although the elective program might be continuing we can admit that patient into ASU II. This is important, because if one understands addictive personalities—and I have been in this field a long time—these people want help immediately, they do not want to wait for it. This is the uniqueness we have allowed the community to have; the person can get treatment immediately rather than waiting. It has also allowed the general hospitals not to keep the patient there for an indefinite period, but to clear them up medically and refer them to us for treatment. In other words, this has helped the hospitals alleviate some of their problems, and it avoids having their beds cluttered up by people the hospital can only dry out and toss back to the community.

**Mr. Conway:** I gather you have a substantial referral from the industrial community in the Lakeshore catchment area. Could you indicate how that has developed, and what is its present state?

[2:00]

**Dr. Maharaj:** From the Lakeshore catchment area we have all the large companies like Ford, Goodyear and Bell Canada; and even the civil service and the police department. Any person from industry who has a problem can refer the patient to us. We are in the process right now of creating a sort of form for Ford of Canada to use across the country in identifying somebody who has alcohol or drug-related problems, realizing this malady can be treated. Our relationship with industry is exceedingly close.

**Mr. Conway:** As of this date, where do you and your unit stand with respect to a future at Lakeshore? What have you been told in so far as the closure of the hospital is concerned?

**Dr. Maharaj:** I have taken what the administrator initially said, that the hospital closes on September 1, 1979, but I have been told that the alcoholic services will stay. As of today, I am just continuing with the idea the program would stay in the hospital. If it is not going to stay in the hospital, there should be an alternative place in the community.

I was rather perturbed to learn that one of the suggestions made was that it become a day hospital only. This is absolutely impossible. Nobody can do that for the simple reason that centres like Donwood and Homewood and other places are allowed to

have both inpatient and outpatient treatment programs. I cannot see, and I would not take the responsibility, of having somebody only on a day basis, asking him to dry out at home. That is an awful responsibility and I am not prepared to take that responsibility. I feel some sort of inpatient program should be maintained. As of this day, I am just continuing and the program is just carrying on.

**Mr. Conway:** Can you indicate from whom you heard the rumour or the report that you might become just a daycare centre?

**Dr. Maharaj:** It was mentioned, I think in the speech the minister made initially, that it will be a day hospital.

**Mr. Conway:** I don't recall that.

**Mr. McClellan:** Just to clarify, Dr. Maharaj was referring to the January 1979 announcement of the closing.

**Mr. Lawlor:** Just to get the figures, there are 46 beds and you treat 300 persons a year, approximately. You have an after-care service.

**Dr. Maharaj:** Yes.

**Mr. Lawlor:** I have a figure of 50 individuals, approximately, in that; is that correct?

**Dr. Maharaj:** In the after care it is 210.

**Mr. Lawlor:** Have you heard anything about their locating you in a disused school building?

**Dr. Maharaj:** No. The idea that it would be relocated as a day hospital suggested that we might have to find some other place in the community. I was told that probably the only place we could find is some school. I believe that schools are B-3 and have to be changed to B-2 to become institutional. We looked around the community to find suitable places. Unfortunately there are no schools in the community that could house the program I have. It would cost an astronomical sum to bring one up to health standards, as well as up to the standards of the fire marshal; we have looked around.

**Mr. Lawlor:** I just want to repeat your very sage words, "an astronomical sum." Hansard, please pay attention.

**Mr. McClellan:** They might put it in block letters.

**Mr. Lawlor:** In block letters, yes.

I just want to commend you on the work you have done. You are well known in the Lakeshore. The need in this particular area is just overwhelming. I even think the ministry has come to that recognition from the

fact that it has to concede the retention and maintenance of that unit—I think where it is.

**Mr. McClellan:** I have a couple of questions, Mr. Chairman. I wanted to ask the doctor if he has experienced staff cuts within the alcohol program as a result of the general layoff.

**Dr. Maharaj:** No, I have not experienced staff cuts. On the contrary, the only two people I am concerned about are my secretary and the admitting officer who have worked to build the program with me and know the ins and outs of the program. I think they have worked diligently.

On the contrary, after closing the hospital was mooted, when I suggested I needed more staff for a long period of time I was told I will be getting more staff. I find it very difficult to handle four segments of a program with my present staff.

The first is the elective program, which is the 28-day program. The second is ASU II, which is the detox rehabilitation. The third is ASU III, which is the after care. While we are dealing with a sort of treatment, I feel also I need a staff for prevention. I think this is what I am trying to aim at; that we need staff both for treatment and for prevention.

I want to clarify one thing here, Mr. McClellan. The Addiction Research Foundation, for example, is given a mandate for research only; they are no longer in the health delivery field. I think it is time we had more facilities for the health delivery field.

**Mr. McClellan:** I couldn't agree with you more.

How is it you were able to avoid the fate that befell the behaviour therapy unit? Was it simply that your staff had been working for a longer period of time and had sufficient seniority that they didn't experience cuts?

**Dr. Maharaj:** As Dr. Bond put it very clearly, we deal both with management and with union people. I think, basically, I was lucky that some of my staff had considerable seniority and a tremendous amount of expertise. I think I was lucky.

**Mr. McClellan:** Taking into account your own statement of professional integrity with respect to the imperative of retaining an inpatient facility for a viable alcoholism and drug addiction unit, if you were to move the unit from Lakeshore to some other location in the community, how much would it cost? Have you done any cost projections, or can you give us an educated guess?

**Dr. Maharaj:** Unfortunately, I can just give you a guesstimate here. We were looking at



one school that I thought was suitable for us, but we couldn't lease or rent the school in any way and they wanted \$1 million for the purchase of it. Then it had to be brought up to fire regulations with sprinkler systems, et cetera.

We looked at another school; this was the "C" school. I am sure some of you know what the "C" school is, with graffiti all over the walls, et cetera. To bring that up to par would be in the region of between \$200,000 and \$300,000. The rental they wanted there was in the region of \$115,000 to \$120,000 per annum. These are the figures I have had so far.

**Mr. Pope:** Doctor, you heard Mr. Lawlor discuss the minister's concession that the alcoholism treatment program continue, perhaps at the Lakeshore site. If that were to come about, are there any problems you can see other than the potential staff problems that Mr. McClellan indicated in his questioning?

**Dr. Maharaj:** Not really, I wouldn't see any great problems. I think that, basically, we have the support of the general hospitals, and I think we can deal with most of the patients from the psychiatric point of view. I think if the persons are absolutely psychotic or extremely disturbed, I am sure we could refer them to Queen Street for the control of their behaviour and then they could be referred to us again. So I don't see any great problem in that area.

**Mr. Pope:** Have you been in charge of any of the maintenance or replacement budgets of your program in terms of the physical facility you are operating in?

**Dr. Maharaj:** I was not in charge of any budgets at all, except that I was fortunate once again in that my unit is run by what I call a democratic dictatorship; that is, there is one dictator and all the rest are democrats. I have run the unit totally; it is absolutely spick-and-span. The patients have to behave. In fact, they can't even take cups of coffee anywhere outside the dining area. My patients have to have a bath every morning before going to the program, with clean underwear and so on. In other words the maintenance costs have been very low. I can assure you right now that with this large complement of patients the space is too small. I find it very difficult to manage. I would like a bigger place in another unit, it is as simple as that.

**Mr. Pope:** Had you been planning to make a presentation for that kind of enlargement, and had you any ideas of what the cost of that might be?

**Dr. Maharaj:** I haven't a clue on the cost, but I hadn't been thinking of planning. We

had initially spoken to the administration and I brought this concern up with them. They looked at the concern and they looked at some of the other units to which we could transfer. However, we could make only minimal changes in the other units for me to be accommodated, so I decided to stay where I am.

**Mr. Pope:** What size of expansion were you looking at?

**Dr. Maharaj:** I needed another complete floor.

**Mr. Pope:** Have you had an opportunity to observe and assess the outpatient programs at the Lakeshore Psychiatric Hospital, and do you have any opinions in a general way as to whether or not they can remain at the Lakeshore site?

**Dr. Maharaj:** You mean the other programs?

**Mr. Pope:** Yes.

**Dr. Maharaj:** I think I have been most complimentary about our community services; I think they have done a magnificent job. They have also been a very good referral source for some of my patients, because I have had lack of staff in my after care for individual therapy or family therapy. With the number they have had I cannot see them being based in the community as such. I think the way they are set up right now is quite ideal for any referral, from either the community or from us.

**Mr. Pope:** Do you feel you would have any problems with support and backup from Queen Street in your program?

**Dr. Maharaj:** I could say I would have support from Queen Street, but realizing what Queen Street is going to go through with the number of patients they are going to get and the large catchment area I empathize with them a great deal. They are going to get a tremendous amount of admissions and I just wonder if they will be able to cope with some of the people we really want to refer to them. I think in the long run they might accommodate us, but when the outpatient services expand I think the admission rate is going to be very high. How they are going to cope with this excess admissions, I just don't know. It is going to be a case of who comes in and how serious you are.

**Mr. Pope:** Is that based on your estimate of the admission rates that Queen Street will experience?

**Dr. Maharaj:** That is what I feel.

**Mr. Pope:** In a hypothetical sense, if your program was located in some other facility



in the community, serving the same population, would there be any problems other than the cost?

**Dr. Maharaj:** No. I think the other problems I would face would be to make sure that the other departments, such as behaviour therapy, the community services, be retained at all times. I also feel that I do have the backup of the general hospitals; I am not concerned about that at all, because I have had a good relationship with them.

I have the community agencies to support me. My major concern would be psychiatric backup in a psychiatric hospital, and how much backup I would get on that. That has been my major concern.

I think one has to appreciate that right now the majority of patients we see do finish off in psychiatric hospitals; I would like to see a relationship created with Queen Street that we get more referrals from them for our treatment program to relieve some of our beds so they can deal with the patients they should be dealing with.

**Mr. R. F. Johnston:** One of my questions has basically been asked by Mr. Pope, so I will ask it the other way round in a positive sense rather than make it a question about Queen Street. Are there advantages, and if there are any could you list them, to having your unit involved with an active treatment institution like Lakeshore, right on the same grounds?

[2:15]

**Dr. Maharaj:** When we started the program, a number of people felt a stigma about going to a psychiatric hospital. I look at it as a successful program, because irrespective of it being based in a psychiatric hospital or based on a correctional centre we must have been doing a good job because people were coming to us and being referred to us. I think it's important that I have psychiatric backup no matter where I go.

At Lakeshore it has been very easy for me, especially when I have somebody who is very disturbed, to refer him to one of the other units and to follow him up in the other unit. At the same time, once that problem has been cleared that person is referred back to us. So I think this easy access and quick access has been a tremendous asset at Lakeshore. If a patient had to be transferred from point A to point B, we have been able to do the shift quite easily in the hospital. That transition has been something on which I have been very complimentary at Lakeshore.

**Mr. R. F. Johnston:** In your view, do the same kinds of advantages affect the other outpatient programs, to varying degrees?

**Dr. Maharaj:** Oh yes, I think they definitely would. Part of my job at Lakeshore is I am a duty doctor at times. There have been a number of patients under treatment through community services who have become depressed or psychotic and needed immediate hospitalization. It is quite easy to just go across the grounds and have them admitted back into the facility.

**Mr. R. F. Johnston:** What kind of interaction is there between the various outpatient programs, your own included? Do they meet?

**Dr. Maharaj:** Yes. We have medical staff meetings, we have medical advisory meetings, we have senior program meetings, we have impromptu meetings; I think we have a very close working relationship.

**Mr. R. F. Johnston:** That would be lost if things were split up around the community, or at least it wouldn't be as easy.

**Dr. Maharaj:** Exactly; it wouldn't be as easy.

**Mr. R. F. Johnston:** There was an article in the Toronto Star, and the headline runs: "Etobicoke Alcoholics Have Nowhere To Turn." I don't know if you saw it; it was just from two days ago. I'll just read it: "The Addiction Research Foundation operates four detoxification centres in the city with a total of 72 beds, but there are no centres outside the downtown core." Is that the case?

**Dr. Maharaj:** That's true.

**Mr. R. F. Johnston:** I understand there is a difference between detoxification and what you're doing. The other thing is: "The Ministry of Health spokesman told the Star that plans for a detox centre in Etobicoke have not been cancelled. Mr. Enright said the matter is now in the hands of Etobicoke General Hospital administration." Have you heard anything about that?

**Dr. Maharaj:** Yes, I think this detoxification centre thing was started about two years ago. It's still in limbo; I think they're trying to find a place. I couldn't wait any further and I felt frustrated, so I started my own at Lakeshore. I feel there is probably a need for detoxification, but once again, I stand by my biases. This is not only my personal bias—there has been a lot of work done in the field—but I just feel detoxification is only a Band-Aid solution to a problem, and eventually this individual is going to finish up in a psychiatric hospital or with brain damage

in a general hospital. This is my major concern, that we look at long-term prophylaxis.

**Mr. R. F. Johnston:** Is this article a reflection of the fact that alcohol abuse in Etobicoke, or wherever at this stage, is greater than the treatments available? I'm not sure I understood you properly, but you mentioned you had not done any active advertising of your ASU II program. If you had do you think you'd be swamped?

**Dr. Maharaj:** I definitely do think so. If you look at the fact 236 people came in a four-month period without any advertising, you can wonder what would happen if you did advertise.

**Mr. R. F. Johnston:** If I can move on from that, if you did advertise and promote this more—which I think isn't such a bad idea if the need is out there—you would also, presumably, need that much more support from the base institution.

**Dr. Maharaj:** Correct.

**Mr. Chairman:** Thank you very much, Dr. Maharaj. I think the consensus seems to be you're doing very good work and providing a very important service. We thank you very much.

**Dr. Maharaj:** Thank you.

**Mr. Chairman:** Dr. Frank is the director of the special observation unit at Lakeshore.

**Dr. Frank:** That is correct.

**Mr. Lawlor:** I guess I'll begin the questioning. You're retiring fairly soon.

**Dr. Frank:** June 30.

**Mr. Lawlor:** Do you look forward or backward to it?

**Dr. Frank:** I'm retiring chronologically, but I'm not retiring.

**Mr. Lawlor:** What do you mean, "chronologically?"

**Dr. Frank:** The regulations state that when you reach the ripe, young age of 65 you have to retire. I don't feel it and I don't think I look it; and that's it.

**Mr. Chairman:** We concur with the latter.

**Dr. Frank:** Thank you.

**Mr. Lawlor:** You of course read, had some input to, and are thoroughly cognizant of the McKinsey report. Do you affirm or accede to its major premises and conclusions?

**Dr. Frank:** Definitely. I feel the same as Dr. Bond does.

**Mr. Lawlor:** Your job basically has been with the special observation unit at the hospital, which was open until fairly recently. Could you describe what that work consists of for the committee?

**Dr. Frank:** In May 1976, it was quite evident we were having too great a number of compensation cases involving staff being injured by aggressive patients. There was also a concern about having extremely homicidal, extremely suicidal, aggressive people on the so-called "open" wards in the seven other wards of the hospital. Therefore it was the brain-child of the previous administrator, Dr. Wayne McKerrow, and our present medical director, Dr. Bond, that we should run a pilot project of a smaller unit that provided medium security. By "medium security" we mean a measure of safety for the patient, also a measure of safety for fellow patients in addition to staff and visitors.

As I said, in May 1976 this 10-bed ward above the admitting ward and next door to or in the same unit as the mentally retarded unit, was brought into being. I was working in admitting at that time, and I took this on as an extra project. It ran for a little over a year. My staff consisted of 10 male nursing assistants. I didn't have any nurses. I had contact with the nurse on the mentally retarded ward, who looked after medication and this and that, but otherwise I had 10 on staff. At the end of a year, the staff and the administration looked at the project and thought it was serving quite a useful purpose. Therefore it was decided, in August 1978, to enlarge this unit from 10 beds to 25 beds.

This was done. We then constituted an SOU I, which was the medium security ward for acutely disturbed, acutely homicidal, acutely suicidal, very aggressive, belligerent people, and those on warrants of remand from the courts; and an SOU II, which was a sort of transition. Once they had settled down sufficiently they could go to minimum security and then perhaps back out to society or back to their wards.

In addition to a lot of the staff being injured and what not, there was the point that it freed the other seven units so they could be truly open wards. In other words, anybody who was disturbed came to our ward. Our intake was from within the hospital; again suicidal, homicidal or very aggressive patients, those from the community brought in by the police and those referred from other hospitals.

It also gave us a little more assurance of the warrants of remand that were sent from the courts. This consisted of an order by a judge for 30 or 60 days, in which time we assessed them, wrote a report, and sent them back to the courts. Sometimes you felt a little uncomfortable if these people were quite aggressive or elopement risks. It was sort of uncomfortable not to be able to pro-



duce that patient for the courts when we were through with the assessment.

I don't like the penitentiary-jail system as such, but there is a certain proportion of people who require this type of care.

What amazed me, since the closure of the hospital was announced and the closure of my ward, is the number of people who have phoned in. Actually, I thought it was quite humorous, the degree to which this ward was quite popular. I wouldn't think that a medium security unit would be appreciated or what not. However, it made me feel good.

**Mr. Lawlor:** How many beds were there just prior to the closing of the ward?

**Dr. Frank:** It was a 25-bed unit, but in the last four or five months my patient intake has been 30 to 36. It is a variable figure; however, the average over the last six months I would say was between 32 and 36.

**Mr. Lawlor:** Dr. Frank, did you protest to the ministry, your putative superiors, about the closing of the ward?

**Dr. Frank:** The closure of the ward was instituted while I was on my annual vacation, and I felt a little perturbed that this was done. Immediately on Monday morning when I came back I approached the administrator. He gave me a hearing and said he would look the thing over. The committee met again and decided that the closure had progressed to such a degree that it was not reversible at that time. Being a civil servant and what not, I follow the administration. Whatever they say goes. I carry it out, whether I agree with it or not.

**Mr. Lawlor:** Except, being a very good civil servant, you came on a television program with me to protest. I admire the degree of courage, independence of mind and integrity of the individuals appearing before us. Civil servants or not, they have an obligation, a somewhat broader obligation than what that wretched oath constricts them to.

Anyway, I don't understand. At Queen Street, were they taking the court warrant cases there and also forwarding some cases to you at the same time?

**Dr. Frank:** There have been occasions in the last three years where we accepted patients from Queen Street who required a medium security setting.

**Mr. Lawlor:** They would be referred there in the first instance and then would be referred over to you. What would the reason for that be? Why would they be sent on to you?

**Dr. Frank:** Because Queen Street works on the philosophy of open wards and these

patients just weren't able to function on an open ward. There is a hard core of patients who require some degree of being locked in. They can have privileges up to a degree, under supervision, this and that, but if not, the police would do nothing else but bring back our runaways, our elopees.

**Mr. Lawlor:** Yes, I see. What does Queen Street do now that it has got all these cases?

**Dr. Frank:** I wouldn't know. I am not in a position to comment on just what goes on. I have been in touch with Dr. Wayne, my counterpart at Queen Street, and he is very co-operative. We have had discussions and he has seen all the Lieutenant Governor's warrants that are going to be transferred in the near future, so that the transition may be as smooth as possible. When I asked him what he was going to do with—I have two definite chronic elopees; if I give one the privilege of going over to OT, five minutes later he is at the Almont and 10 minutes later he is uptown somewhere; time will tell.

**Mr. Lawlor:** The Almont, in case anyone is interested, is the local celebratory hotel, right across the street from the hospital. What are you doing at the present time?

**Dr. Frank:** I am working in an admission unit and I have taken the bulk of my SOU patients with me. At present I have 12 on an admission unit, but because of safety reasons and what not, and other patients, our second floor on ward three now is locked. It is a matter of necessity.

**Mr. Lawlor:** I see. Was it in your unit that some patient was responsible for this fire that has so burned the rear end of the minister?

[2:30]

**Dr. Frank:** No; I am SOU, that was SOC.

**Mr. Lawlor:** Oh.

**Dr. Frank:** That was a mentally retarded—

**Mr. Lawlor:** It wasn't a patient of yours?

**Dr. Frank:** It was SOC; in self-care. It was a former patient of mine, yes, I'm sorry to say.

**Mr. Lawlor:** But not at that time?

**Dr. Frank:** Not at that time, no.

**Mr. Lawlor:** Thank you.

**Mr. Chairman:** Mr. Pope?

**Mr. Pope:** Where are you now; in admissions?

**Dr. Frank:** I am on an admission ward, ward three.

**Mr. Pope:** Ward three at Lakeshore?

**Dr. Frank:** That is correct.



**Mr. Pope:** And you have taken, you say, the bulk of your SOU patients with you?

**Dr. Frank:** About half of them. Half went to ward four with my former assistant, and I took the sort of hard-core cases with me to ward three.

**Mr. Pope:** And you say that what you have done is keep ward three locked?

**Dr. Frank:** One floor, yes.

**Mr. Pope:** One floor locked?

**Dr. Frank:** It was actually locked off and on in the past because of security reasons.

**Mr. Pope:** And you are doing that because of the special problems. I didn't quite catch it; can you define the difference between SOU I and SOU II?

**Dr. Frank:** The original ward, SOU I, was medium-security; it was a locked ward within a locked ward, which gave us medium security.

SOU II was the surrounding area of SOU I, which gave us minimum security with one locked door. With two locked doors, it gives us medium security.

**Mr. Pope:** Are there any other security arrangements?

**Dr. Frank:** There are special screens on the windows on the inside. Wherever possible, we put in a special form of Plexiglass. Any sharp objects are covered. The furniture is that type that you can't injure yourself with too much. The floors are carpeted. The staff is well experienced in handling aggressive types of people and the other types I mentioned.

**Mr. Pope:** Were you saying that there were 25 beds in each of the units, or in total?

**Dr. Frank:** No, the total. The new unit that was opened in August 1978 was increased from 10 beds originally in the pilot project to 25 beds.

**Mr. Pope:** Okay. And that is both SOU I and SOU II?

**Dr. Frank:** That is right.

**Mr. Pope:** Okay. I was not sure about that. Then you mentioned that you are averaging 32 to 36 beds.

**Dr. Frank:** Patients. We would have to set up extra beds.

**Mr. Pope:** You do set up extra beds?

**Dr. Frank:** Yes.

**Mr. Pope:** And how many extra beds have you regularly set up?

**Dr. Frank:** Up to 35 or 36.

**Mr. Pope:** Extra? Or is that total?

**Dr. Frank:** No, no. Ten beds extra.

**Mr. Pope:** Okay. You dealt with this a bit, but what is the average length of stay in the SOU II?

**Dr. Frank:** A matter of about five to seven days. However, I might mention that in the unit I have a hard core of 10 to 12 patients who just can't be handled in an open setting; that is stationary.

**Mr. Pope:** Is that in SOU II?

**Dr. Frank:** Yes.

**Mr. Pope:** Okay. So it is 10 to 12 steady?

**Dr. Frank:** Or patients who every so often act out in an unacceptable or aggressive fashion. I keep them for five to seven days and send them back to their wards; then somebody else acts out and comes. So the turnover is quite heavy.

**Mr. Pope:** Is it similar for SOU I?

**Dr. Frank:** The security is the only difference; and, of course, privileges are definitely cut down.

**Mr. Pope:** I am sorry; I meant length of stay.

**Dr. Frank:** Oh. It's approximately the same. When patients who are aggressive, or acting out, or psychopaths, alcoholics and addicted people, come in, they usually settle down within 12 to 24 or 36 hours. We keep them another couple of days for observation and then discharge them into the community or refer them to the other wards or to other agencies.

**Mr. Pope:** I think you indicated recently some concern about some problems with some of your patients in the SOUs, that if they mixed with other patients there might be some harm to the other patients and perhaps to the staff. Have you now got any information on incidents that have actually happened to substantiate that fear?

**Dr. Frank:** I haven't got them enumerated as such, but they are an ongoing concern in our facility all the time.

**Mr. Pope:** Have they escalated since the SOUs were closed?

**Dr. Frank:** No, with the incidents, three and four aren't as tranquil as they were two months ago.

**Mr. Pope:** Has anyone been physically injured?

**Dr. Frank:** They smashed windows and cut themselves. There have been a couple of instances where they pulled a patient out of the lake. It's only been since March 26.

**Mr. Pope:** Yes, I understand that. You are talking about patients who do harm to

themselves. Has there been any harm that they have committed on other patients or on staff?

**Dr. Frank:** There have been a couple of incidents where there has been a minor injury. A black eye, and a bruise.

**Mr. Pope:** Have they required medical treatment?

**Dr. Frank:** Minimal, luckily.

**Mr. Pope:** How many incidents was that? I am sorry, two or three I think you said.

**Dr. Frank:** I'd say about four or five in the last couple of weeks.

**Mr. Pope:** Okay. This is abnormal in terms of the operation of wards three and four?

**Dr. Frank:** I should probably mention here that when the special observation unit was functioning it also acted as a deterrent. If you didn't behave on wards three or four or any other wards you would be sent to SOU I, with loss of privileges and confinement.

This is something that you can't analyse very scientifically or statistically, but I am sure it's the general impression that you can draw, which as far as I am concerned is valid.

**Mr. Pope:** I understand the deterrent factor that you have been discussing is the incidence of harm done from one patient to another or from a patient to a staff member. You recall four or five incidents in the last couple of weeks. Is that abnormal?

**Dr. Frank:** No, it varies considerably. I don't know if it has to do with the pull of the moon, or this, that and the other thing, but it certainly is an up-and-down figure.

**Mr. Pope:** How many Lieutenant Governor's warrants were there in your special observation units?

**Dr. Frank:** When it closed, seven.

**Mr. Pope:** Immediately prior, let's say in November and December and January, what would you average?

**Dr. Frank:** Six or seven.

**Mr. Pope:** Where would they be? Would they be in SOU I?

**Dr. Frank:** SOU II.

**Mr. Pope:** From your experience, did you find that they were more dangerous than other patients, that they were likely to do harm to others as well as themselves?

**Dr. Frank:** On the contrary, they are probably the easier type of patient to handle, and you ask yourself, why?

First of all, they have spent anywhere from two to 10 years in Penetanguishene in a maximum security unit; secondly, when they come down they are under the jurisdic-

tion of the administrator, and I carry out, working with him, whatever the warrant states. The important thing there is there is a so-called yo-yo clause. In other words, if you don't co-operate with the programs and what not, without any consultation I apply to the administrator and they are back to Penetang in a matter of hours, and this to me is a real deterrent.

I received five Lieutenant Governor's warrants since November. Of those I have four—they are on loosened warrants—who are working steadily, and the fifth one is mentally incapacitated but is coming along and will probably start work in the next two weeks.

I would like to point out here too that there seems to be some misconception about Lieutenant Governor's warrants, that they are bloodthirsty murderers, this and that, so and so; this isn't the case at all. These people have committed a crime, they are guilty by reason of insanity, they have spent some variable time in Penetanguishene where the programs are excellent—they use behaviour modification, they use reality and responsibility therapy, and they use group therapy—and by the time they come to me they have made some progress, so I just carry on the rehabilitation into the community.

The other thing, too, is that of the 17 Lieutenant Governor's warrants I have now, one is absent without leave—which we knew would happen—three are in the community and see me once a month. That leaves 12 inpatients. Those 12 are scattered around the hospital and only three are designated as "safely keep," and one of those is "safely keep" but may go out with a responsible individual. So you get a large variety. Every warrant is different and each of these warrants has to be treated on an individual basis.

**Mr. Pope:** When patients are put into the SOUs are they restricted to that area and not allowed to leave that area or are they allowed to leave with supervision? What are the arrangements?

**Dr. Frank:** Again, it's individualized. For the first 12 to 24 hours they're in pyjamas; no privileges. I may even restrict the smoking privileges. This continues and as they co-operate and improve, their privileges are increased.

**Mr. Pope:** The 12 patients that you have kept with yourself in ward three—

**Dr. Frank:** Seven.

**Mr. Pope:** I'm sorry, seven. I thought you had said 12.



**Dr. Frank:** No, there are a total of 12 Lieutenant Governor's warrants in the hospital as a whole.

**Mr. Pope:** And you've kept seven with you?

**Dr. Frank:** I kept seven on special observation unit, but when the special observation unit was disbanded then a certain number went to four, some went to A, some went to B and some stayed out with me on three.

**Mr. Pope:** Okay. Special observation units; are they a normal part of other psychiatric hospitals in the United States and Canada?

**Dr. Frank:** There are more of these in the United States and out west. I believe we're the only one in Ontario outside of St. Thomas which has the female counterpart but which is also maximum security.

However, in the past year, people have come from other Ontario hospitals to look at this unit. The ministry, for a while decided they would open up four or five of these units spread around Ontario to serve the purpose I outlined when I started to tell you what the unit was like.

**Mr. Pope:** Have you heard of any controversy concerning the concept of the units?

**Dr. Frank:** Strangely, any criticism has been very sparse.

**Mr. Pope:** Is it fair to say that you wouldn't categorize patients—this is my last question and thank you very much for your information. Is it fair to say that you would not categorize patients in special observation units as dangerous people?

**Dr. Frank:** Mainly, they would be dangerous at a certain point in time but we can't predict when someone is going to act out.

Say we have a chronic patient in the hospital on another ward. They go along fine for eight months and there is no change in medication and, for no obvious reason, they go what we call up the pole. They get very disturbed. They are sent to the observation unit and when they settle down they are sent back.

As I say, this has worked. We used to have quite a few of these patients around the hospital and they may have taken one or two trips to the special observation unit; they've gone back to A or B, or say the chronic unit, and we don't see them very often. I get a nice "good morning" from them off and on in the grounds.

It's amazing. There must be a good degree of immaturity in a lot of these people because they relish discipline—kind, firm discipline—like the youngsters do.

**Mr. Pope:** Thank you for your help.

**Mr. R. F. Johnston:** My first question will be just a followup again to Mr. Pope's, and that means just a very straightforward answer I presume. You are committed to the concept of these units, are you?

[2:45]

**Dr. Frank:** Yes, I think they are essential because the unit frees the rest of the hospital to carry out programs. It's quite disconcerting to have, say, an admission unit of 40 beds and have a couple of acting-out psychopaths and an alcoholic, the three of them get along, whereas the day before the ward was tranquil and everything was going along fine, and these three people just upset the whole ward. I think the other 37 patients are suffering on account of this.

My philosophy is different from Queen Street's and Dr. Wayne's. We're good friends and we agree on a lot of things, but we don't agree on this point.

**Mr. R. F. Johnston:** Do you think we should talk to him and find out his view?

**Dr. Frank:** Off the record I think he is in favour of this type of unit and he has asked for it for five years but never got it. Last week I had Dr. Boyd down, who is the previous medical director of Penetanguishene, and I explained what was going to happen and I said: "Can I quote you that you are in favour of special observation units?" and he said yes.

**Mr. R. F. Johnston:** My next question follows up on the Penetanguishene situation. There are some people who would argue, and I don't know if you agree with them, that the decline in institutional bed usage in psychiatric hospitals has a direct correlation to the increase in the number of people behind bars in other kinds of institutions, and that the only psychiatric institution that has increased in population over the last number of years is the Penetanguishene institution. You have already said a doctor from that institution feels that your kind of unit can play a very important role as far as they're concerned as well.

**Dr. Frank:** Yes, I've discussed this with the medical staff, in particular Dr. Bond, and we agree that this aggressive type of acting-out patient is increasing. Marital disputes are increasing. If one of the spouses takes a knife to the other, and they can come to a unit like I have, the patient actually feels better because he knows that he can't carry out any threat, and deep down he probably doesn't want to, and the spouse is certainly reassured that this man can't walk out of the hospital. I don't see how



you can keep someone like that in an open ward. I don't like to see people behind bars, but for a certain length of time I think it's an absolute necessity.

**Mr. R. F. Johnston:** I think I heard you say something to the effect that some of the patients who go through your program go back through Dr. Maharaj's program sometimes if there is an alcohol connection.

**Dr. Frank:** Yes, we're a backup. He can handle the majority of these disturbed patients chemically, but there are some who are just too obnoxious, and if that's the case then I admit them and as soon as they're settled we contact each other and they're sent over. By the same token, in reverse, if one of his patients appears to have settled for three or four days and all of a sudden, during or after withdrawal becomes quite disturbed, he is sent over. All Dr. Maharaj does is pick up the phone and in a matter of five minutes the patient is back on my ward and settled. Then he is referred back again. When you asked Dr. Maharaj about this I think he explained it very well. Our relationship among the various units, community services, alcohol services, the social orientation centre, the whole lot, is a smooth operation.

**Mr. R. F. Johnston:** All interwoven.

**Dr. Frank:** Interwoven, yes. As I said, when the special observation unit was closed I went around to all my colleagues and it was unanimous that they thought my unit should continue.

**Mr. R. F. Johnston:** I do have a lot of questions but I thank you for that. I presume that you only had, as you say, a short while to watch the reaction of having these patients in another form of control outside of your own specialized unit in the hospital. I'm not sure if Mr. Pope was concerned about people swimming in March or not when he asked the question, or how severe he sees black eyes, et cetera.

Mr. Lawlor asked a question of the minister in the House on March 29, to ask him whether or not he could guarantee that there would not be major disturbances on the wards because of the ending of your unit at that time, and the minister's response was: "I will be glad to talk with the staff in the psychiatric hospitals branch to assure myself that the decision that has been taken is not causing any harm to the patients."

Did the members of staff from the psychiatric hospitals branch contact you or somebody else that you know of at Lake-

shore to check to see what the situation was?

**Dr. Frank:** No.

**Mr. R. F. Johnston:** Thank you very much. Are you at this point concerned about the acting out? Do you think that under the present arrangements you have it under control as far as you are concerned?

**Dr. Frank:** I have some concerns. On the second floor, which is locked, in ward three at the present time, there is glass and people can jump out. We've had about five incidents in the last two years. They jump out from the second-storey window. I feel uncomfortable that some morning I'm going to walk in and I'm going to get a call at home. This is unpredictable. Again, it's a matter of perhaps there's a carryover; they have been moved physically, but a number of my staff have gone with me and they still think mentally that they're on the special observation unit. I just thought of this the other day. I don't know how logical that sounds to you, but it makes sense to me.

**Mr. McClellan:** Just to follow that up, some of the staff at the hospital told me about an incident on March 22 on ward three, which I think was just a couple of days before the unit was closed.

**Dr. Frank:** That's correct.

**Mr. McClellan:** Was there an assault incident against a member of the staff that you can recall around that time, that involved staff being assaulted by a patient and kicked in the head?

**Dr. Frank:** Yes. I wasn't involved in that. I'm not involved unless they are referred to me.

**Mr. McClellan:** Admission was closed at that point in time, was it? That would be March 22; would admissions to the units have been closed by that point in time?

**Dr. Frank:** No, the admissions to our hospital aren't closed.

**Mr. McClellan:** I mean to your unit.

**Dr. Frank:** Oh; March 26.

**Mr. McClellan:** So you didn't get a referral of a patient who had assaulted a staff member between March 22 and March 26?

**Dr. Frank:** If I recall correctly, I was called about it. In the interim with chemotherapy and what not, the patient settled down. I was prepared to take that patient, but it wasn't necessary. That's the other thing too, there was a big concern that if you have a unit like that it's going to overflow all the time, the people are going to

misuse it. I can say without any reservations that we had certain criteria set up before you could admit. They certainly weren't misused at all. The rest of the staff has told me it is a good feeling to have a unit like this in reserve.

**Mr. McClellan:** Right, and in the course of the normal operations of the hospital prior to the closure announcement, I would assume that that would be one of the uses that would be made of your unit, when a patient, as you say, goes up the pole and beats up a member of the staff. You would isolate them there for the wellbeing of program and the protection of staff.

**Dr. Frank:** To me, it would be only logical to assume that if prior to May 1976 when it was the concern of the previous administrator that all these compensation cases were on such an increase, in due time this will recur. The cause is still there.

**Mr. McClellan:** Right. Just as a final comment, this ended up as a compensation case, a compensation claim being filed.

**Dr. Frank:** We're limited. We're working on a skeleton staff actually compared to some of the other hospitals. When one or two or three members are off, this throws the whole thing out. Your programs are disrupted and it's disconcerting in addition to all the injury and upset that there is to the staff themselves.

**Mr. McClellan:** What I wasn't clear about in this particular incident was whether—you may not be able to help me with this—the staff person suffered the assault because the patient who was out of control was not able to be referred to the unit, or whether the referral was recommended after the assault.

**Dr. Frank:** It would probably be referred afterwards, unless there was some indication of acting out.

**Mr. McClellan:** That's why I was asking if you had any recollection.

**Dr. Frank:** No, I'm sorry I don't.

**Mr. R. F. Johnston:** My last question, and follow-up questions to it, goes back to what happened to you as you returned from holiday. You discovered upon getting back to the hospital that the decision had been made to close down your ward. When you went to see Mr. McMullen did you ask him about how this decision had been made?

**Dr. Frank:** Yes. There was a committee set up to decide what wards are going to go when. They look at the pros and cons and make the decision. When I explained the situation and gave my side of the story,

he reconvened the committee. They made their decision and it came out in the negative.

**Mr. R. F. Johnston:** Is this an entirely in-hospital committee, or are there ministry officials on it?

**Dr. Frank:** It is an in-hospital committee confined to Lakeshore. What other input there was, I wasn't aware of. I wasn't prepared to debate the point that heavily in view of the closure and my imminent retirement.

**Mr. R. F. Johnston:** You did take the opportunity to speak with Mr. McMullen and indicate your concerns. He then reconvened the committee in order that you could have a chance to speak to them.

**Dr. Frank:** No, I wasn't included in the discussions.

**Mr. R. F. Johnston:** But he took your concerns back, as far as you know.

**Dr. Frank:** Yes. I also spoke to my medical director, to whom I am responsible initially, and voiced my concerns. Then he carried this on further.

**Mr. R. F. Johnston:** Your private discussion with the other program directors all just indicated regret?

**Dr. Frank:** That's right. I wanted it to be unanimous, and it was unanimous luckily, just for personal backing.

**Mr. Lawlor:** You may know that another question was asked with respect to a young woman; her name isn't important on this occasion. She was in the special observation unit and had some kind of self-destructive background. Immediately after your unit was dissolved some of the people in there became voluntary patients in effect, and in any event were free to walk out of the hospital. Do you remember this particular young woman leaving the hospital?

**Dr. Frank:** No, I'm sorry, I don't. What happened there is that I tried to cut down my census on the ward prior to moving them to wards three or four, or other parts of the hospital. Certain patients were discharged a little sooner that I would have wished. Perhaps I would have kept them another week or two or three, and then prepared them; but I had to take a calculated risk. Moving a lot of patients, if I could keep it down it made more sense.

**Mr. Lawlor:** This is an awkward question—

**Dr. Frank:** You may get an awkward answer.

**Mr. Lawlor:** That was what I was awkwardly hoping not to get. Was there something insidious, something deliberate, in closing this unit with you absent?

**Dr. Frank:** I don't know. I don't like to contemplate that. As I said, the unit was quite well received by the majority. Probably one of the concerns was indirect. When that unit was closed it made available 22 staff, and they were short of staff. Four of my staff went directly to Queen Street. This was, I think, part of the decision too. Mr. McMullen has stated to me that the machinery had all been in motion and these 10 nurses, four of whom were on my staff, were due to be transferred to Queen Street. The machinery had been set in motion and it was hard to reverse it.

**Mr. Lawlor:** All I can say is that from the point of view of the ministry, knowing your dedication, knowing the degree of your commitment to this particular program, they would have anticipated, had you been on the spot, that it would not perhaps have been quite as easy to make the move.

To go on to the second part, if you hadn't an imminent retirement, I dare say you would have fought back more strenuously. [3:00]

**Dr. Frank:** I think you may have a point there.

**Mr. Lawlor:** Thank you.

**Mr. Chairman:** Thank you, Dr. Frank, we appreciate your attendance. We wish you well in your retirement, or any other pursuit you decide to take up.

Is Mr. Suttis, the maintenance department head, here?

**Mr. Conway:** While Mr. Suttis is coming up, Mr. Chairman, is it our plan to deal with all the witnesses on our list?

**Mr. Chairman:** Except the Ontario fire marshal and the inspector from the Etobicoke Fire Department. We will be dealing with those people next week.

**Mr. Conway:** Mr. Suttis, Mr. Barnes, Mrs. Royce and Mrs. Best are the witnesses we had to call today.

**Mr. Chairman:** Yes; and Mr. Fisher, Mr. Anderson, Mrs. Latimer and Mrs. Jones.

**Mr. McClellan:** This might be an appropriate time to ask whether the Ministry of Government Services report that was promised by the minister to the committee on Monday has been delivered either to yourself or to the clerk?

**Mr. Chairman:** It hasn't been delivered to me.

**Mr. McClellan:** I wonder if you could make some follow-up inquiries as to whatever happened to that document.

**Mr. Chairman:** Indeed, immediately.

**Mr. Conway:** Mr. Suttis, you are maintenance department head. That mandate means exactly what, in so far as your responsibilities at the hospital?

**Mr. Suttis:** That means maintenance of the physical plant and equipment.

**Mr. Conway:** So that gives you a good opportunity to comment on the state of that physical plant, generally speaking. You see most of it in the course of your work?

**Mr. Suttis:** On a daily basis, yes.

**Mr. Conway:** You have been at Lakeshore how long?

**Mr. Suttis:** Nine years.

**Mr. Conway:** I presume you have seen this document that was presented today. It is a statement of the moneys spent at Lakeshore in the past.

**Mr. Suttis:** No, I haven't seen it.

**Mr. Conway:** We will talk about that in a moment. How would you characterize, from the point of view of maintenance and just general plant condition, the quality of that facility that you have been associated with?

**Mr. Suttis:** Actually the buildings are sound, structurally sound, and over the nine years I have been there we have upgraded continually. There are still deficiencies and there always will be, such as heating. In much of the hospital we can't control the heat, it is on or off, and we need better distribution for hydro.

**Mr. Conway:** Those are phenomena that really aren't untypical of that kind of series of cottages of that age; and I right?

**Mr. Suttis:** Yes, or any age. We are always upgrading.

**Mr. Conway:** The impression was left in the minds of a number of people—I dare say a number of members of the Legislature—that there was out in that Lakeshore campus a real firetrap. Is Lakeshore, in your mind, a firetrap?

**Mr. Suttis:** I don't think so.

**Mr. Conway:** Has it ever been a firetrap?

**Mr. Suttis:** Ever?

**Mr. Conway:** In your time there?

**Mr. Suttis:** No.

**Mr. Conway:** So you are quite confident that, in a relative sense at least, the facility is both structurally sound and safe in a fire sense?



**Mr. Suttis:** Yes. We can vacate a ward in three minutes and have done it many times, and it takes the fire trucks about three minutes to arrive after the alarm goes, so it doesn't seem to be a problem.

**Mr. Conway:** You would have no doubt then that the facility, with the kinds of renovations that have occurred—I roughly calculate the expenditure of about \$1.75 million in the past five years according to the capital projects at Lakeshore, if I read that list correctly, and I stand to be corrected, but I just went through it very quickly, roughly \$1.75 million spent in the last five years out there—

**Mr. Suttis:** My estimate was \$1.4 million, so it isn't far out.

**Mr. Conway:** Mine would be a little higher than that, just looking at 1973-74, where there was \$1,073,000, and 1977-78, where there was \$362,000, and I am just reading the top figures. At any rate, there was a substantial amount of money, in the neighbourhood of \$1.5 to \$2 million, spent in that five-year period, so presumably that facility is in the kind of condition you've described and could be, with reasonable funds made available, carried forward for another five, 10 or 15 years without any real difficulty?

**Mr. Suttis:** Yes, I would say so.

**Mr. Conway:** Have you sensed, as maintenance department head, that you were going to be phased out and, therefore, moneys were not as available as they might otherwise be? Or have you really been able to get the money you needed for the things you wanted done?

**Mr. Suttis:** Yes, there was no problem to maintain the place. We had to do many small renovations over the years. I would say about 40 per cent of our man hours are spent on this kind of thing for different programs.

**Mr. Conway:** That vocational training unit—I don't know what the exact name of the building is, but it's the new building there since 1973—that certainly is in very good condition, having been built only five or six years ago. What are the plans, that you're aware of, for that particular building assuming the closure of the hospital?

**Mr. Suttis:** I have no idea.

**Mr. Conway:** I think that's all.

**Mr. McClellan:** Sean did establish the main point. The ministry provided us, Mr. Suttis, with a number of documents, in particular a document from Mr. Manson, consultant for the fire prevention and explosion

hazards section of the institutional planning branch. It was a fire safety report on the Lakeshore Psychiatric Hospital delivered to the hospital in May, 1978. Are you familiar with that document? Was that something that was brought to your attention?

**Mr. Suttis:** I don't seem to remember it.

**Mr. McClellan:** Maybe I'll just hand it to you and you can look at it and tell me whether it was something that had been brought to your attention.

**Mr. Suttis:** Oh, yes.

**Mr. McClellan:** There are a number of recommendations in there. Have any of the recommendations been acted upon?

**Mr. Suttis:** These recommendations came, I think it was in May, and that was after submission time for jobs. The administrator asked me if I would itemize all the parts that we couldn't do; there were too many jobs for us. I did, and I gave him the report. I think it was \$217,000 worth of work. There were many small items included in that.

**Mr. McClellan:** When you say \$217,000, that was the work that you could do yourself or was that the total?

**Mr. Suttis:** That was for MGS.

**Mr. McClellan:** That was the total cost of implementing those repairs?

**Mr. Suttis:** That was my estimate, yes.

**Mr. McClellan:** You had never heard of a figure of \$2.5 million bootied about as the cost of doing the work that is indicated in the Manson report?

**Mr. Suttis:** No.

**Mr. McClellan:** In your estimate it was \$217,000?

**Mr. Suttis:** I have it itemized if you'd like to see it.

**Mr. McClellan:** Yes, I would. What I would ask you to do, Mr. Suttis, if you could, is to table it as an exhibit with the committee, because it's an enormously helpful piece of information for us. I would like to give Mr. Suttis a moment to obtain the document that he wishes to table. I think it would be helpful if he was able to leave it with the committee chairman. If that's your only copy we could perhaps have it reproduced.

You submitted the itemized statement, which you have been so kind as to provide to the committee. What happened to it then? Were you then authorized to begin some of the work, or was it something that had to be set over for the next budget period?

**Mr. Suttis:** There are many small items in the report which we could do ourselves. That's not included.

**Mr. McClellan:** So you proceeded to do the work that you could do yourselves. Was that work completed?

**Mr. Suttis:** Much of it. It's ongoing, anyway.

**Mr. McClellan:** The \$217,000 is just work that you couldn't do yourself?

**Mr. Suttis:** That's right. It wasn't work that we couldn't do, there was just too much of the maintenance department to do simultaneously.

**Mr. McClellan:** Was some of that contracted out?

**Mr. Suttis:** None of this work has been done.

**Mr. McClellan:** None of it's been done? Why not?

**Mr. Suttis:** I don't know. Normally we would put that on submissions but we didn't do submissions. It was too late for submissions. So we haven't made any out this year because of the closing.

**Mr. McClellan:** The normal sequence would have been to put those items into your budget submission and submit them to the ministry.

**Mr. Suttis:** For MGS to do, yes.

**Mr. McClellan:** Have you been asked to submit cost estimates for other renovation work of an extraordinary nature within the same period of time?

**Mr. Suttis:** No, I don't believe so.

**Mr. McClellan:** That is, aside from the ongoing work of maintenance at the hospital?

**Mr. Suttis:** No.

**Mr. Lawlor:** I'm told, Mr. Suttis, that the life expectancy of the extant buildings could be fairly indefinite, and should be 20 years or so. Have you any comment to make on that?

**Mr. Suttis:** As I say, the structures are sound. When I say that, there are some reservations. On the north side, in the spring we sometimes have flooding in some of the basements and sometimes the plaster falls off the tunnels, but generally speaking the buildings are sound.

**Mr. Lawlor:** They are good solid buildings too. Those walls are very thick.

**Mr. Suttis:** Four feet thick.

**Mr. Lawlor:** Four feet? It sounds like Fort York. We don't expect the Americans to visit, do we? A statement was issued and

a letter was written to the local newspaper, the Etobicoke Advertiser-Guardian, by the executive of the Association of Volunteers, Lakeshore Psychiatric Hospital. The letter repeats in effect the same comments as to expenditures of moneys in the recent past. The letter is dated February 1, 1979, and on page two it says:

"We, the taxpayers, are also concerned with the unnecessary utter waste in tearing down sturdy functioning buildings that have recently received improvements at a cost of over \$2.5 million." They run down as follows: "New Hydro systems, installing, \$250,000." Can you confirm that?

[3:15]

**Mr. Suttis:** My figures are verbal, received from Government Services. The substation and the two vaults, which are new now, amounted to \$168,000.

**Mr. Lawlor:** This is a new set of documents that has arrived. Have you ever seen those?

**Mr. Suttis:** No, I haven't seen those.

**Mr. Lawlor:** I think we are asking where they are from and what they are about, but no one seems prepared to tell us. Leaving little things aside, let me just peruse this for a moment. Your figure rings a bell. Might Mr. Suttis be given a copy of this document I am looking at? It was distributed yesterday I think.

**Mr. Duksza:** By the minister?

**Mr. Lawlor:** Yes.

**Mr. Duksza:** Ah, that's why we don't know what it's all about.

**Mr. Lawlor:** Yes, it comes from the ministry. On page five, it shows minor capital raised in 1977-78, fire alarm improvements \$44,000; replace transformer volts, north and south, \$200,000. The total is \$244,000. Hasn't anybody else got this? No? Give one to Mr. Suttis immediately.

I am not going to take you through the whole detail. I trust the committee will give this list a good going over. I don't think it's necessary to take enormous time to do it. There is just one thing, at the end, sir, page six, you say you did not identify works carried out by the hospital's maintenance staff but only those from the Ministry of Government Services. So this may not represent the whole picture by any means, I take it.

**Mr. Suttis:** Actually, we have nothing to do with this. This is strictly Government Services and they don't normally tell us these costs at all, but I ask them usually. That's the only reason I have any figures



on it at all. The maintenance costs, of course, our maintenance, that's another story.

**Mr. Lawlor:** If you take page five, for instance, 1977-78, item 5, there is a whole string of matters that have been improved, relatively small sums of money spent on them, but I would take it that they are brought up to good working condition and are acceptable — everything from boiler repairs to excavation of the creek mouth.

**Mr. Suttis:** Yes. These jobs have all been done.

**Mr. Lawlor:** Right. There are pages and pages of these improvements that have been made, reaching back to 1974-75. In other words, they have spent a lot of money on this and they are now apparently prepared to see it go down the drain. That's my main point. Would you contest the sum given by the hospital volunteers of \$2.5 million within the last five years? Would you think that was inaccurate?

**Mr. Suttis:** I don't know where they got their figures.

**Mr. Lawlor:** I was beginning to run over some of them and I will do that. They mention the new roof, \$80,000.

**Mr. Suttis:** As I say, my estimate is \$1,405,000 for approximately the last five years. This is not internal maintenance or anything like that. This is work done by MGS.

**Mr. McClellan:** That you requested through submissions?

**Mr. Suttis:** Some submissions. They have what they call their maintenance budget too. This is for small things like roads, eaves-troughs and things like that.

**Mr. Lawlor:** The trades and industrial therapy building was erected in 1974 at a cost of close to \$1 million.

**Mr. Suttis:** I understand it was \$800,000.

**Mr. Lawlor:** To erect such a building today would cost more.

**Mr. Suttis:** Much more.

**Mr. Lawlor:** Three or four times as much.

**Mr. Suttis:** Possibly.

**Mr. Lawlor:** Have you any idea what that is going to be used for?

**Mr. Suttis:** None.

**Mr. Lawlor:** I will save my questions for the next witness.

**Mr. Belanger:** Mr. Suttis, I believe you mentioned that you have been in charge of maintenance for nine years. You must know those buildings from end to end and top to bottom.

**Mr. Suttis:** And before that, I was 14 years in here.

**Mr. Conway:** We'll not ask you to comment on the condition of this place.

**Mr. Belanger:** The McKinsey study recommended a total renovation or rebuilding of Lakeshore. Do you agree with that recommendation?

**Mr. Suttis:** Yes. I don't make policy, of course.

**Mr. Belanger:** What do you think these recommendations were based on? You mentioned a few problems of heating and hydro distribution.

**Mr. Suttis:** It is quite obvious it isn't a Queen Street. The buildings are 90 years old. I would say, yes, it is time they were replaced, but at the same time they are solid structures.

**Mr. Belanger:** What has been your biggest maintenance problem in the Lakeshore buildings? What part of the hospital buildings or equipment needs the most repairs?

**Mr. Suttis:** I run a preventive maintenance system which looks after the equipment pretty well, so it isn't a big problem. In the buildings, probably the greatest problem I have is loose plaster. It seems to come off, and I don't know why. Even on inside walls the plaster comes off in big blobs. It keeps a plasterer going steadily.

**Mr. Belanger:** The maintenance that you are looking after would seem to be the day-to-day maintenance.

**Mr. Suttis:** Yes.

**Mr. Belanger:** The major maintenance would be done by the Ministry of Government Services?

**Mr. Suttis:** Yes. We do what I like to call "pure maintenance." If a toilet plugs, we unplug it. Preventive maintenance comes next, and renovation comes third.

**Mr. Belanger:** Renovations are the most expensive portion.

**Mr. Suttis:** It depends how many you do, of course.

**Mr. Belanger:** I understand you have areas where, for patient safety, windows must be kept locked.

**Mr. Suttis:** In most of these types of areas we have blocks on windows, so they go up so far and then they hit the blocks and they don't go any further. Is that what you mean?

**Mr. Belanger:** My next question will probably determine what I meant. I am informed there is no air conditioning.



Mr. Suttis: No.

Mr. Belanger: How do you keep the rooms sufficiently cool in summer with the windows almost closed? It must be like an oven.

Mr. Suttis: Quite a few areas have cross ventilation, if the windows are open on both sides.

Mr. Belanger: When it is 100 degrees outside, even cross ventilation would not do much to cool down a room.

Mr. Suttis: No. They need air conditioning, no question about that.

Mr. Belanger: I suppose in a building with walls of that thickness, everything would be better kept closed. As a last question, have you had many maintenance emergencies in the past five years, such as bursting of water pipes or breaking down of the heating or hydro system?

Mr. Suttis: Two or three, I would say. One was the steam line in the winter; it had to be repaired right then. Another one was a hydro vault, due to a big storm.

Mr. Belanger: Which could happen anywhere.

Mr. Suttis: Yes. I can't think of any others at the moment.

Mr. Belanger: That is all, Mr. Chairman.

Mr. Pope: Did you say you agreed or disagreed with the recommendations in the McKinsey report?

Mr. Suttis: My own personal opinion is I agree.

Mr. Pope: You prepared a set of estimates, which Mr. Lawlor has. Are those estimates that you would normally prepare for budget purposes?

Mr. Suttis: No. Normally we would put this on submission, as I say, to Government Services, because \$217,000 is a bit much for a maintenance department.

Mr. Pope: Would you normally estimate the value of the work to be done by Government Services?

Mr. Suttis: No. They would come and estimate it.

Mr. Pope: Have you had any significant increase in your maintenance staff over the time you have been there?

Mr. Suttis: No, a decline. It was 32 when I went there; before the closing announcement it was 24.

Mr. Pope: During the time you have been involved at Lakeshore, has there been any change in the budgetary allocations for maintenance and renovations and repairs?

Mr. Suttis: I would say in my budget there has.

Mr. Pope: We are all subject to inflation.

Mr. Suttis: It has increased about that amount actually.

Mr. Pope: You prepared an estimate—I think you said it was \$217,000. That was to implement the recommendations of a report?

Mr. Suttis: Yes.

Mr. Pope: And that was the part of the renovations and repairs that had to be done that would have been done by MGS?

Mr. Suttis: Yes.

Mr. Pope: Did you then value work that had to be done by your own staff?

Mr. Suttis: No, I didn't.

Mr. Pope: Was it mainly a labour component in that work that you were to do, and you felt you had staff to do it?

Mr. Suttis: Yes, trivial jobs such as changing doors, put an exit light here and there, things like that.

Mr. Pope: On top of that, had you prepared a budget submission for the regular maintenance and repair and renovation costs for this current year? Had you prepared that last fall?

Mr. Suttis: No. We prepare them in the spring.

Mr. Pope: Had you prepared them last spring?

Mr. Suttis: No.

Mr. Pope: Who would prepare those?

Mr. Suttis: I prepare them, but when this report came out it was too late, it was past time.

Mr. Pope: I understand that. Had you already prepared your normal budget submission?

Mr. Suttis: Yes.

Mr. Pope: What was the amount of that?

Mr. Suttis: I can't remember now. We used to put in about 20 to 30 submissions on various things.

Mr. Pope: You would cost them out?

Mr. Suttis: Yes, with the help of Government Services people we would put an estimate on them.

Mr. Pope: You can't recall any ballpark figure of what it was going to be?

Mr. Suttis: No. There are so many of them. Would you like to see one?  
[3:30]

Mr. Pope: It's okay. You stated that air conditioning was needed. Have you given any thought to what that would cost?

**Mr. Suttis:** No. It depends on so many things. It would have to be decided, do we need air conditioning in every place? When functions change, maybe we would not need air conditioners in certain places. We did not get that far, because we did not have the hydro to run air conditioning available.

**Mr. Pope:** Just one final question: Are you in the midst of a phase-in program for replacement of the electrical system?

**Mr. Suttis:** Yes.

**Mr. Pope:** And you have completed phase one now?

**Mr. Suttis:** Actually the substation is complete. Then, from the substation, the power goes to two vaults; and they have been renewed with new transformers.

**Mr. Pope:** Right.

**Mr. Suttis:** The last phase is to take the power from the transformers to the buildings—rewire the buildings.

**Mr. Pope:** Rewire the buildings?

**Mr. Suttis:** Yes.

**Mr. Pope:** Do you have any estimate of how much that will cost?

**Mr. Suttis:** No.

**Mr. Pope:** Are you aware of any other ongoing projects that are in different stages of completion?

**Mr. Suttis:** Not in different stages.

**Mr. Pope:** Are you aware if there are some that you yourself or others have planned?

**Mr. Suttis:** There were some projects that we had hoped to get done, but they have not been started.

**Mr. Pope:** What were they?

**Mr. Suttis:** We needed a new kitchen ceiling, for one thing.

**Mr. Pope:** Right.

**Mr. Suttis:** We needed a patient cafeteria, for another.

**Mr. Pope:** A cafeteria?

**Mr. Suttis:** Dining room.

**Mr. Pope:** Are there any others?

**Mr. Suttis:** Those are the only two.

**Mr. Pope:** Thank you, Mr. Chairman. I think my friend wants to continue.

**Mr. Duksza:** Mr. Suttis, you said you had accepted the recommendation of the McKinsey report that the place should be rebuilt. Am I right?

**Mr. Suttis:** Oh, yes; of course.

**Mr. Duksza:** Tell me, if it became too expensive, the idea of spending that much

money for rebuilding, do you think the buildings, with a minimum investment, could be brought up to even better standards than they are right now and be serviceable?

**Mr. Suttis:** As I mentioned before, we have been upgrading steadily. For instance, last year the Ministry of Government Services installed two fire exits; we had been asking for them for years and years—eight years, in fact—and they were installed last year. There is a continual upgrading in the buildings.

**Mr. Duksza:** But what I would really like to know is your opinion, as a professional and as an expert, on whether the buildings are serviceable and whether, with some minimal improvements, they could be made much better and still useful for the delivery of psychiatric care?

**Mr. Suttis:** Actually, the facilities are probably better than would seem to be the case to people. About five years ago we installed a new sewer line right around the place at an expense of, I think, \$70,000. We have two watermains coming in; so if one goes off, we always have the other one for fire. It is almost impossible to be without water. Those kinds of things are pluses for the hospital.

**Mr. Duksza:** How long could those buildings last with good maintenance and some extra investment?

**Mr. Suttis:** It depends on whom you ask, of course.

**Mr. Duksza:** Fortunately, I am asking you.

**Mr. Suttis:** I have heard it said it could be another 10 years.

**Mr. Duksza:** Is that your opinion? That they will only last another 10 years?

**Mr. Suttis:** No. It's not my opinion that they would last that long. I have no idea how long they would last.

**Mr. Duksza:** But they would last, basically; so there is no rush, from that point of view, to demolish them. I think we should consider—I hope this is a reasonably open committee and not precluded the way we had established yesterday by the minister; so if we are not precluded, we could talk about the question of—

**Mr. Pope:** We didn't establish it.

**Mr. Duksza:** I think we did. Let's hope that we are, in fact, an independent legislative committee, which can make some decision on whether this thing should stay, be demolished or changed.



**Mr. Conway:** Socialist hordes.

**Mr. Dukszta:** I am perfectly open now, and I hope to persuade Mr. Conway, as I think he is already half persuaded, that the Lakeshore should stay with some improvements for the sake of all those people who live in that area and would have a need of psychiatric services, but that's for the members rather than for the witness to decide.

I have a question, then, for Mr. Suttis. Did I hear you correctly, that you said it was not, in your opinion, a fire hazard? When did the whole discussion of it being a fire hazard start, actually? Did it start in the hospital or did it start somewhere here? Did you ever have any discussions of it being a fire hazard?

**Mr. Suttis:** No.

**Mr. Dukszta:** No one in the whole of the hospital discussed that it was a fire hazard?

**Mr. Suttis:** We have said in the past there was a slight possibility the wiring could create a fire hazard. This would be more to push for. As I said, it took eight years to get two doors in. It would have been more of a problem than anything previously to try to get the rewiring job done.

**Mr. Dukszta:** But now that you have got those two fire exits—or what is it that you've got recently you've been pushing for for eight years?

**Mr. Suttis:** Yes, two fire exits.

**Mr. Dukszta:** So in your opinion, then, that would have made it even safer?

**Mr. Suttis:** Our problem was the wiring, and this was quite a problem. We need more distribution from these two vaults that we have. They are new vaults, but we need distribution to the buildings. Housekeeping equipment, in this day and age, draws considerable power, so we are constantly blowing fuses and breakers with this equipment. We actually need more distribution. We have the power but we need it distributed to the buildings.

**Mr. Dukszta:** As the head of the maintenance department you participate on the management committee? Is that what it's called, the chief management committee?

**Mr. Suttis:** I'm not on the management committee, no.

**Mr. Dukszta:** Which committee do you then participate on? I'm not sure of the actual structure.

**Mr. Suttis:** The supports department.

**Mr. Dukszta:** Do you remember it ever being on an agenda that this was a fire trap or a danger to patients?

**Mr. Suttis:** No.

**Mr. Dukszta:** Would I be correct in saying then, that this diagnosis of Lakeshore being a fire hazard is like diagnosing a disease in a patient without seeing the patient?

**Mr. Suttis:** Possibly so.

**Mr. Dukszta:** Yes, that's typical of our minister, thank you.

**Mr. R. F. Johnston:** Dr. Dukszta stole a couple of my—

**Mr. Dukszta:** I didn't hit him on the head to say yes. He said yes, he agreed with that.

**Mr. R. F. Johnston:** This is probably overkill on that area, but the kind of report that was shown to you by Mr. McClellan that you remembered seeing afterwards, listing a number of fire safety inadequacies if you will, is a regular kind of thing that is done either by fire departments in some municipalities or by offices within the government to help update buildings. It's not something which says that if you don't do these things tomorrow morning the place will burn down. Isn't that the case?

**Mr. Suttis:** We get the reports. We also get a regular report from the Etobicoke fire marshal's office too. They inspect the place periodically, once a year or something. They always give us a report. We go ahead, as soon as possible and ongoing, to do all these jobs that they tell us need to be done.

**Mr. R. F. Johnston:** And usually there is scheduling for that, some of them over several years to see if you can get this done.

**Mr. Suttis:** It's an ongoing thing; we get the reports, I think, once a year.

**Mr. R. F. Johnston:** The other things I was going to ask you are just to sort of clear things up. Has there ever been, that you remember, a 100-degree day in the area of the hospital?

**Mr. Suttis:** No.

**Mr. R. F. Johnston:** I didn't think so. A lot of the wards do have a lot of cross-ventilation and it's not a problem?

**Mr. Suttis:** That's right.

**Mr. R. F. Johnston:** The thickness of the walls in fact often helps, I presume, on a summer day, rather than hindering. My father happens to be involved in physical plant maintenance at a university where they have new and old buildings. He told me of a principle he follows in terms of preventive maintenance, and that is that after a certain number of years any new building starts to cost as much as any of the older buildings. They have buildings that were built in the



1840s and 1850s on that campus. Is that a principle you endorse?

**Mr. Suttis:** Many of my colleagues who work in new buildings tell me that, yes. They go along with that.

**Mr. R. F. Johnston:** Just because you happen to have a new building, it doesn't mean that in some cases some of those costs may not become quite severe within four or five years.

**Mr. Suttis:** Look at city hall. The roof leaks.

**Mr. R. F. Johnston:** I don't know if the mike caught that, but he said city hall is a good example, where the roof leaks—a problem they don't have. That was just a principle I wanted to ascertain. The kinds of costs I've seen, including the ones from the Ministry of Government Services, which include some major repairs and renovations as well, don't seem to me to be inordinate for the scope of those buildings you have.

**Mr. Suttis:** Oh, no.

**Mr. R. F. Johnston:** Okay, I'm glad you agree with that.

**Mr. Suttis:** They are only one-time shots, for example, new roofs, that will never be done again.

**Mr. R. F. Johnston:** The other thing, and your administrator mentioned it in his statement at the beginning of our questioning, was that your department had been very helpful to them in converting areas from one kind of use to another, as was needed in adapting some of these community-oriented programs, at very little cost, as he put it. You didn't really stress that in the things you've been saying, but I gather you have done a fair amount of that kind of work.

**Mr. Suttis:** Oh, yes. To set up all these programs there were changes to be made and we have always worked very closely with the administration and the department heads and unit directors. We've had a good working relationship with them, and that really helps.

**Mr. R. F. Johnston:** I do believe, as I look through my notes—I've changed the order of them several times—that those are all my questions.

**Mr. Chairman:** Thank you very much, Mr. Suttis. We appreciate your attendance.

**Mr. Lawlor:** What is your future?

**Mr. Suttis:** I have my walking notice. My layoff notice is for September 1.

**Mr. R. F. Johnston:** How many years was that?

**Mr. Suttis:** I have worked 23 years with the government, nine at Lakeshore.

**Mr. Lawlor:** Are they seeking to find an alternative spot for you?

**Mr. Suttis:** I see no evidence of it.

**Mr. Lawlor:** There isn't, eh?

**Mr. Suttis:** No.

**Mr. Lawlor:** We were told they were bending over backwards; performing gyrations.

**Mr. Suttis:** I'd like to see some of that bending over backwards, actually.

**Mr. Lawlor:** You'd like to see that?

**Mr. Suttis:** Yes, I would.

**Mr. Conway:** Just on that point, you weren't planning to retire voluntarily in the next few years?

**Mr. Suttis:** No, I don't want to if I can help it because the penalties can be pretty severe.

**Mr. Conway:** I just want to pursue Mr. Lawlor's point—I think it's a very important one—that people in your position have not been provided for in any way. There's no sign of it?

**Mr. Suttis:** No. As I said, I've seen no evidence whatsoever.

**Mr. Conway:** And you have given 23 years of service to the Ontario Public Service.

**Mr. Suttis:** Yes.

**Mr. Chairman:** How old are you, Mr. Suttis?

**Mr. Suttis:** Fifty-eight.

**Mr. Conway:** That was the question I wanted to ask, without being quite that direct.

**Mr. Chairman:** Thanks very much, Mr. Suttis.

**Mr. McClellan:** May I take a minute before we proceed to the next witness, Mr. Chairman? I have a concern based on the evidence that came out earlier this afternoon with respect to the threat to the behaviour therapy unit at Lakeshore. We have had evidence from a number of sources that that particular outpatient service is very much at risk. That conflicts with statements the minister has made, in his closing speech in January and in communications to various members of the public, and to us in this committee when he made his opening statement, to the effect that outpatient services would be maintained and enhanced.

I would like to ask you to arrange, possibly with the steering committee, the ap-

pearance at the earliest possible time of either the minister or some senior official who can deal with the reality—that it isn't true; that, as a matter of fact, the behaviour therapy clinic is very much in jeopardy. We will want some assurance that there will be no deterioration of outpatient services during the transition period, some assurance that that, in fact, isn't happening.

**Mr. Conway:** I just wonder if perhaps Mr. Jappy would be an acceptable witness in that connection.

**Mr. McClellan:** I would leave it to the steering committee to determine who the appropriate person is to be, whether it's Mr. Jappy, or Dr. Lynes or, in fact, the minister himself, since he is the one who gave us the assurance. That assurance doesn't seem to be holding up and we should try to schedule that as early as possible next week.

[3:45]

**Mr. Chairman:** I think that can be arranged, Mr. McClellan. Dr. Lynes is slated for Monday; the minister is to reappear on Wednesday. I think we can work with the steering committee and perhaps arrange something.

**Mr. McClellan:** Thank you very much.

**Mr. Chairman:** I should mention at this point the MGS report will be in the clerk's hands tomorrow morning. If we could arrange to get a copy to the caucuses of each party—it is a 130-page report—

**Mr. McClellan:** We don't need four copies of that report; if we could have one copy that would be fine.

**Mr. Chairman:** One per caucus would be sufficient, agreed? Fine.

I should mention at this point that Mr. Morin, the administrator of the Hamilton Psychiatric Hospital, is here. Since he is from out of town, would it meet with the approval of the committee to have Mr. Morin come on at this time? What is your wish in that respect?

**Mr. Duszta:** As long as we can make sure Mr. Barnes stays.

**Mr. Conway:** We did plan to sit until 6 p.m. and Mr. Barnes is very much in the flow of this last discussion, it seems to me. I am wondering whether or not we couldn't deal with Mr. Barnes and then Mr. Morin?

**Mr. Chairman:** Is that the wish of the committee?

**Mr. Conway:** That is assuming we are not going to take more than a half hour.

**Mr. Chairman:** That would avoid a break-up in the flow of information. If that is satisfactory, we will proceed on that basis.

**Mr. Conway:** I just have one series of questions that deal with the matter that occupied some of our—

**Mr. Lawlor:** May I just interject for a moment? I wonder if Mr. Barnes has seen this very large envelope having to do with fire safety at three different hospitals, including Penetang, which was submitted to us in the last couple of days?

**Mr. Barnes:** I have not seen any report on any hospital other than Lakeshore, Mr. Lawlor.

**Mr. Lawlor:** I don't know how we can adequately deal with this if Mr. Barnes has not been clued in as to the various—they are quite elaborate reports.

**Mr. Barnes:** I have seen Lakeshore's, but it would be very difficult at short notice to go through what appears to be a voluminous file on some other hospital and compare the two or three, or whatever.

**Mr. Lawlor:** If you look at the Whitby thing, it is almost as thick and shows, in my layman's opinion, a far more hazardous condition generally speaking. I would like Mr. Barnes to peruse these documents prior to testimony if that seems worthwhile from the point of view of the committee. Then he has the whole picture of what is supposedly before us.

**Mr. Conway:** I could not altogether disagree with that, Mr. Lawlor, but I think there is some benefit, particularly in the light of the discussion with the previous witness, to get some initial comment on the general question of fire safety at Lakeshore. I am not suggesting that your point is an invalid one, but I—

**Mr. Lawlor:** What I am prepared to do then is to stand down to your questions. You have your list of running questions and that is fine, but before I begin my questioning I would like this to take place.

**Mr. Chairman:** I wonder then, in view of that, if we could deal with Mr. Barnes today in terms of fire safety at Lakeshore. Then, Mr. Barnes, if it were convenient for you to peruse this other document to which Mr. Lawlor has referred, perhaps you could return on a subsequent day, if that is satisfactory.

**Mr. Lawlor:** That seems to be in order.

**Mr. Barnes:** If the committee feels I could comment with any kind of authority on some other facility, then I am at the behest of the committee.



**Mr. Lawlor:** No, we will stick to Lakeshore today.

**Mr. Conway:** Mr. Barnes, your exact jurisdiction at the hospital is what?

**Mr. Barnes:** I am basically the chief engineer. As a corollary to that I am the fire safety officer. That's part of my job spec.

**Mr. Conway:** How long have you been responsible for fire safety, and how long have you been at Lakeshore?

**Mr. Barnes:** I have been at Lakeshore since July 1958, which makes it almost 21 years. I have been the chief engineer and fire safety officer for about a month short of nine years.

**Mr. Conway:** On a point of information regarding what Mr. Lawlor was commenting upon a moment ago, does the course of your work at Lakeshore give you an opportunity to see and experience the conditions in respect of fire safety in other provincial psychiatric hospitals?

**Mr. Barnes:** I have visited other psychiatric facilities in southern Ontario for various reasons; but I am not party to their fire safety programs as such.

**Mr. Conway:** But you are at least passingly acquainted with the patterns and the standards in some other facilities?

**Mr. Barnes:** Yes, I would say that.

**Mr. Conway:** Just a personal question on the nature of your employment: what has your condition been as of the end of January? Have you, like Mr. Suttis, been provided with absolutely no redeployment?

**Mr. Barnes:** I am exactly like Mr. Suttis and a fair number of other employees.

**Mr. Conway:** You don't sense that anything has been or is being done to reassign you within the Ontario public service?

**Mr. Barnes:** Absolutely not.

**Mr. Conway:** Now the main question, and it is that of fire safety. I think Mr. Duktza pointed it out very well in his questioning of Mr. Suttis. There is the clear impression being left by some, and I would suggest it has occurred in the Legislature, that Lakeshore is a firetrap facility—one that is to be closed if for no other reason than that alone—because there has been at least one death in the recent past; this facility is 89 years old, and if we are not careful it will all go up in flames some day very soon.

Within the context of that perhaps rather polemical opening, would you care to comment on how you see the fire safety at Lakeshore hospital, generally and specifically speaking?

**Mr. Barnes:** Generally speaking, as regards the comments to which you referred, regardless of where they emanate, I would disagree with them quite strongly. In my opinion, the fire safety of Lakeshore, including in two phases the actual programming and the physical nature of the facility, would be at least the equal of any other facility run by the province. Who knows, maybe better than some.

I would like to put in at this point—you referred to the fact there was one recent death in a fire. That occurrence was to my knowledge the only occurrence with such consequences in the 21 years I have been there. To the best of my knowledge it is the only occurrence that has ever taken place since the hospital was built. There never has been a fire in that facility caused by its physical condition.

**Mr. Conway:** As the person responsible for fire safety, could you indicate for the information of the committee more of the specifics relating to the one fire-related fatality in the recent past? What exactly happened?

**Mr. Barnes:** Relating directly to the November 18 fire? As you may already know, and for those who don't, that fire was the result of arson committed in that building at about, I believe, 2:45 a.m. The person was later discovered. There was a second fire almost exactly 24 hours after—a very small one outside a building on the opposite side of the property. Various situations of which I'm not fully aware led to suspicion of a certain person; that person was questioned by various people and has subsequently been charged. So it has been stated by several people there was absolutely no fault on the part of the staff or the building related to the death in that fire.

**Mr. Conway:** You as the person responsible for fire safety are quite confident that fatality, tragic as it was, bore no relationship either to a poor quality physical plant or a staff that wasn't vigilant.

**Mr. Barnes:** Absolutely not.

**Mr. Conway:** Just one final point. Mr. Suttis indicated that as a result of some recent improvements in the physical plant the building now might be interpreted to be structurally better than it was in the recent past. I'm wondering, since you've been at the hospital for 21 years, whether or not you might comment on the relative safety of Lakeshore Psychiatric Hospital today with respect to the facility you found when you first went there in 1958 or perhaps in the mid-1960s.



Has there been an overall improvement, in your view? Are fire safety standards better now both because general standards have been raised and because the hospital has itself become more sensitive to and conscious of those standards?

**Mr. Barnes:** I'm glad you qualified that by saying the mid-1960s because if you go back to 1958, as a consequence of my job I really wasn't up on these things. It wasn't too much part of my position then. But as to whether it is more fire safe now than say 15 or 20 years ago, I would say yes it is. It is because of consciousness of the staff; it's because of improvements that were made—I'll just say to the fire alarm system and the awareness of the staff in what to do.

**Mr. Conway:** So in conclusion then, from your vantage point as someone who has been at the hospital for 21 years, who served as the person responsible for fire safety for many years now, it is not an unreasonable conclusion for this committee to state that it is not a fire trap. In other words, Lakeshore Psychiatric Hospital is not the fire trap that some would have us believe.

**Mr. Barnes:** It is not a fire trap, Mr. Conway.

**Mr. Conway:** Thank you, Mr. Barnes and thank you, Mr. Chairman.

**Mr. Lawlor:** As a matter of fact, in that arson, the patient lighted seven fires in the lounge on the first occasion. Is that correct?

**Mr. Barnes:** I was right on the scene shortly after the fire was extinguished and from conversations I was involved in and overheard it was estimated there were seven areas in that lounge that indicated they may have been initial hot spots, yes.

**Mr. Lawlor:** I'm looking at a report by an M. Manson, consultant, fire prevention explosion hazards institutional planning branch. I suppose it's the Ministry of Health; it doesn't say at the beginning here.

One of the hazards there was polyurethane cushions which give off toxic gases. Have you done anything about that?

[4:00]

**Mr. Barnes:** We are somewhat tied. I have verbally and in writing, as recently as three or four months ago, made a comment that we are tied in the type of furniture we can put in these places simply because, to our knowledge, there are no standards for furniture which uses the various kinds of synthetic foams. We have tried to limit it as much as possible, but I'm sure the committee members must be aware the same thing applies to almost anywhere today, from

your own home right into any structure at all. It's very difficult to find anything at all that doesn't contain large quantities of foam.

We tried to take other precautions which recognize the fact that furniture exists, but I think we might have trouble finding things for the patients to sit on if we threw all the furniture out at this stage of the game.

**Mr. Lawlor:** On page four of this document, Mr. Manson mentions the tiling. He said: "The combustible tile in the building was previously treated with a fire-retardant paint and did not, in any measure, contribute to the fuel load of the fire in the lounge." Are you aware of this treatment having been given to the material?

**Mr. Barnes:** I would agree with that statement.

**Mr. Lawlor:** Has that thing been done throughout the buildings?

**Mr. Barnes:** Yes, it has. Many large areas of those buildings were modernized by the installation of acoustic tiles. I'm going back many years, probably even before I first became employed there.

Since that time, it became recognized the type of tile available in those days was combustible. Since we recognized this we have been on an ongoing basis removing those tiles, and replacing them with the modern, non-combustible mineral tiles. When any change takes place in a room or an area, if some of the tiles appear to be damaged, the entire roof space in that area would be ripped apart and the tiles all replaced with mineral tiles. Other areas which have not yet been replaced on that basis have been treated with an intumescent fire-retardant paint.

**Mr. Lawlor:** Is the emergency lighting particularly satisfactory in that building?

**Mr. Barnes:** In the entire hospital?

**Mr. Lawlor:** Particularly in exits and through the corridors.

**Mr. Barnes:** Every door which—I was going to say, is designated as an exit. But every door which leads to the outside, or every door which leads to a means of egress to an outside door has a proper exit fixture placed right above it or right beside it wherever space conditions allow.

Quite often, there are places where there would be more than one. If there were two doors very close to one another which either lead outside or lead to a means of egress then you might find two exit lights within six feet of one another. You will also find lights in places where there are no doors. They hang in hallways leading to or adjacent to a door so that the exit sign is visible

whereas the actual door itself is not. These meet the current standards as to size, colour and any other means of indication besides the word "exit."

**Mr. Lawlor:** I have before me a more elaborate document done by the same gentleman, Mr. Manson. It is quite elaborate except on exit facilities. He goes over, inch by inch, all the buildings picking out, again, in my layman's way, somewhat picayune matters here and there.

**Mr. Barnes:** I'll accept that.

**Mr. Lawlor:** I haven't been able to detect—of course I am not equipped to do so—where a major hazard might exist. As far as I can see, he says exit facilities in the majority of buildings were found adequate and maintained in a satisfactory condition. All buildings containing patient occupancies have recently had exterior metal fire escapes installed in them to provide a secondary means of egress from all levels. In some cases where secondary means of egress from the upper floors does not exist, the floors have been left vacant. Is that an accurate description?

**Mr. Barnes:** That is basically correct. Those secondary means of egress, the metal fire escapes, were installed five, six or seven years ago. I may say for as long as I can remember there were metal exterior fire escapes on certain doors. The ones to which Mr. Manson refers at the extreme ends of those buildings were put in about six or seven years ago.

**Mr. Lawlor:** There was something I missed, which I think my colleague brought forward. What was it you were waiting eight years for the profoundly disturbed ministry to move on, or introduce and they finally broke down and did it last year, because they were terrified of the whole situation?

**Mr. Barnes:** I wonder which one that was?

**Mr. Lawlor:** It could be any number, could it?

**Mr. Barnes:** I was just going to say, I think Mr. Suttis referred to fire doors. We have, going back to 1973, a report from the municipal fire department which notes they had been previously recommended for certain buildings, namely, cottage three and cottage four, which did not have adequate means of egress or adequate secondary means of egress on the grade level.

Those buildings do not have basements as such. They are three floors built directly on grade with a small sub-chase underneath. Their only means of egress up to that time was by means of the main front stairwell

which goes right from grade to the top and by means of a back door leading into the enclosed central tunnel system.

The fire department was concerned with that floor on grade level. There was a large area on each side of the main central hallway which could exceed the recommendations for what is called a dead-end corridor situation. They recommended fire-escape doors be placed in the extreme east and west ends of cottage three and cottage four at grade level. Those are the four doors I am talking about.

As I say, they noted it in 1973 and they noted it again in 1975. By the time the inspection came around in 1978, work was finally under way. The job was completed about August 1978. It really wasn't much of a job but that's how long it took.

**Mr. Lawlor:** There are only two other matters which I think should be on the record and to which I want to make specific reference. One has to do with hazardous locations. On page eight of this report it says, "Hazardous locations in the complex have been restricted to the trades building which houses the carpenter, electrical, mechanical and flammable liquid storage rooms. These occupancies are fire-separated from the remainder of the floor area, and, with the exception of the flammable liquid facility, are all sprinklered." Whatever that is.

**Mr. Barnes:** That, as you are aware, is the newest building on the property. When it was built, in 1974, the entire basement—I'll qualify that; it's not fully a basement, it's half and half.

That area, the entire bottom floor let's say of that building, is on a pressure, wet-sprinkler system; with the exception of what Mr. Manson refers to as the flammable liquid storage area, which is the separate, small hexagonal-shaped building outside the main confines of the trades building.

**Mr. Lawlor:** That's where liquid of this flammable quality is stored.

**Mr. Barnes:** That is where the large quantities of it are stored.

**Mr. Lawlor:** The final thing I want to mention has to do with carpeting. This report says: "It is my understanding that the carpeting used in the corridor and other areas, including sleeping quarters, had been listed with the ULC"—who is that?

**Mr. Barnes:** That's the Underwriters' Laboratories of Canada.

**Mr. Lawlor:**—"or UL"—

**Mr. Barnes:** That's the American equivalent. I don't know what the "I" stands for; I usually just call it UL.



**Mr. Lawlor:** Everything stands for institute—"or ULI, with a flame-spread rating not exceeding 150. The carpeting material in other areas meets with the standard for surface flammability of carpets and rugs, pill test, US federal specification . . ."—so—and-so—" . . . and is not otherwise prohibited".

Is the carpeting safe?

**Mr. Barnes:** The carpeting is safe. You can't drop a cigarette on it and have it burn, no; it makes a little black mark and that's it. It's as safe as anything. I could make almost anything burn if I wanted to.

**Mr. Lawlor:** Those are all my questions for the moment, unless we go on to these other—

**Mr. Barnes:** My job is to stop it.

**Mr. Duktzta:** I would like to repeat some of the questions I asked of Mr. Suttis. I would just put them to establish how far this concern about the fire hazard was being expressed in the hospital. I have worked long enough to know it is one of those more fearsome things imaginable, a fire hazard and the idea of a fire. It brings out all the atavistic elements in us when we think of a fire. So it's very important to deal with it, I think, especially when it has been stated as one of the reasons for closing.

When you are concerned about the possibility, someone complains or someone tells you of a fire hazard in an area, you first deal with it through your own staff; then where does it go?

**Mr. Barnes:** If I understand you correctly, you mean some other staff member?

**Mr. Duktzta:** Let's say you yourself notice something; someone says this is a fire hazard, new evidence comes out, new work is done in terms of inflammability of materials, et cetera. You first discuss it, I assume, with your own staff; then where does it go?

**Mr. Barnes:** I wouldn't discuss it with my staff, no; I don't have staff who are as deeply involved in it as I am. I more or less take it up myself.

I would go and investigate this complaint; or if it was a piece of written material that came across my desk that indicated to me we may have something in our hospital which has now been discovered to be of serious hazard, I would go and investigate this myself. If I needed further information I would obtain it from those people with whom I deal—the municipal fire department, Ontario fire marshal, or whomever. If it's written I'd request further written information from the author. If I were convinced

that indeed we did have a problem, then I would bring this to the attention of my immediate supervisor.

**Mr. Duktzta:** Which would be who?

**Mr. Barnes:** Who would be the assistant administrator.

**Mr. Duktzta:** Have any of those things been discussed in the last six months, that there is a potential hazard? Anything which could be used as evidence by the minister? [4:15]

**Mr. Barnes:** I have never come across anything that would disturb me to that degree. For years we have made sure that such things as carpeting—as has been mentioned—draperies, all meet the existing standards for such things. When any kind of renovation is planned to alter, however slightly, the configuration of a room, depending on a program change, I would be informed about this and could say whether these plans were feasible from a fire safety point of view. In other words, were they going to restrict any kind of safety of the people involved in that area, and if I didn't know I'd get the information from someone else.

**Mr. Duktzta:** You've said, and the administrator, Dr. Bond, and Mr. Suttis have said repeatedly that in their opinion the place is not a fire hazard; it's in fact quite well taken care of and has never been discussed in terms of being a hazard. So my point is really very simple: Where the hell is this information coming from that it is a fire hazard? I just reread the minister's statement. He says, "It's even unsafe." So where does the information come from? Who did he talk to? Maybe he talked to Mr. Pope or someone and they decided to say it is unsafe. I just decided to pick up on him, but it may have been done just as casually as that.

The one other question I would have is: Is there some linkage in terms of fire hazard to Etobicoke? Do you have a contact with the municipality in terms of fire hazard? Do you contact anyone in there?

**Mr. Barnes:** Yes, we do. We have what I would consider to be an excellent relationship with the Etobicoke Fire Department, not only from the point of view of response to a call but from an information point of view. I've absolutely no problem.

**Mr. Duktzta:** Have they ever pointed out to you that Lakeshore is a fire hazard?

**Mr. Barnes:** They have never pointed out to me that Lakeshore is a fire hazard; no sir.

**Mr. Duktzta:** Well, we are very clear now that it is not from the hospital that the information comes about its being a fire



hazard, and it doesn't come from Etobicoke Fire Department, so it must be from within the ministry. I would just be curious to find out who exactly has supplied that wondrous information to the minister. Someone must have; surely he could not have invented it. I couldn't believe that, I mean, it's really too much to think that he would ever do that.

**Mr. Barnes:** Mr. Chairman, may I say something?

**Mr. Chairman:** Yes, sir.

**Mr. Barnes:** I think it has been said before but I'd like to say it personally that I don't particularly care what type of building you are in, an occurrence such as the one we had last fall—since it has been bandied about quite some number of times—as far as I am concerned could happen anywhere.

**Mr. Lawlor:** Yes, the minister was wakened up at 3:30 in the morning and—

**Mr. Barnes:** So was I, and a lot of other people, too.

**Mr. Lawlor:** Very often we are awakened at 3:30. A lot of people go to jail at 3:30 in the morning too.

**Mr. Duksza:** Right now I could get up from this table, move to one of the less protected areas of this august building and set up a fire. It's just simply an accident, but that doesn't mean necessarily that the building is dangerous; it just means that I am becoming crazy from these hearings, that's all.

**Mr. Chairman:** As the rest of the committee knows.

**Mr. Duksza:** Yes.

**Mr. Pope:** Mr. Chairman, I wonder whether Mr. Barnes would agree that providing a secondary means of egress from all floors, including the basement of the administration building, would be a proper fire safety precaution?

**Mr. Barnes:** I would say, since you ask the question, that it's obvious you know that building has only one means of egress from all floors except the main floor, so I would say yes, that building should have a secondary means of egress.

**Mr. Pope:** I am sorry, I am referring to what Mr. Suttis did—a costing—and that's what I am referring to.

**Mr. Barnes:** Sorry.

**Mr. Pope:** Would you say the provision of exit facilities from buildings number three and number four at the ground level is an appropriate fire prevention or fire safety measure?

**Mr. Barnes:** Yes, I agreed with that.

**Mr. Pope:** How about the installation of fixed fire extinguishing equipment in the kitchen? Would you agree?

**Mr. Barnes:** Yes, I asked for that simply because, in my experience, there has only been one minor occurrence in that area. But it became obvious a minor occurrence could easily become something else, as it could in any facility of that type. And I said it should have, as any modern facility cooking for that amount of people is required to have it.

**Mr. Pope:** Would you say it's proper fire safety to have a three-quarter-hour fire rating for doors?

**Mr. Barnes:** All over?

**Mr. Pope:** I can give you the references. There is a reference to doors on either side of the elevator vestibule and at the Humber building there is some discussion of stairwell doors.

**Mr. Barnes:** In the Humber building, it was decided the stairwell doors met standards for many years, since the place was built in 1935 or something, but nowadays, the standard requires at least a three-quarter-hour class c door on that stairwell to make it totally enclosed. We said we wanted that.

**Mr. Duksza:** May I ask a supplementary? When did you ask that this be done?

**Mr. Barnes:** Probably back in 1975. I think you may find it on a report somewhere.

**Mr. Duksza:** And there was no reaction by the ministry to that since 1975? Mr. Pope has surmised you've established that.

**Mr. Barnes:** It was on an actual submission to be done with several other things just prior to the closure announcement.

**Mr. Duksza:** So it took some time before the minister reacted to that? Is that what you are telling me?

**Mr. Barnes:** There were many things asked for over the years and some took a fair amount of time and haven't yet been done. A great many were done by co-operation between our own hospital staff and some members of the Ministry of Government Services. We would do certain parts of the job and the Ministry of Government Services would do certain other ones—not on a contract or project basis, but just an ongoing maintenance basis we could get things done.

**Mr. Pope:** Would you agree that for Cumberland House there would have to be extensive renovations to make sure there are adequate fire safety measures?

**Mr. Barnes:** I wouldn't agree, sir, they were necessary to provide adequate fire safety measures. I think the measures in that build-

ing, as with all other buildings, are entirely adequate as the buildings stand. However, I would agree some renovations should be carried out in that Cumberland building because of the particular internal structure of the building.

**Mr. Pope:** Is this for fire safety reasons?

**Mr. Barnes:** Yes, it's for fire safety reasons.

**Mr. Pope:** You have explained the process by which you have been installing non-combustible tile. Would you agree the remaining combustible ceiling tile should be replaced?

**Mr. Barnes:** I wouldn't go and do it all at once, no; I don't think it's absolutely necessary it be done on that basis immediately. I agree that it should be carried on the way it has been carried on.

I base that on two things: Until November 18 of last year, I had never seen a fire so large occur anywhere in the hospital; and even after November 18, I was still convinced that that ceiling tile did not in any way contribute to the extent of the fire in that area. So I would agree that on a ongoing basis it should be done, simply because there is ceiling tile nowadays which is noncombustible.

**Mr. Pope:** Mr. Suttis mentioned that they had completed the first phase of a new electrical system and that what was left to be done was a complete rewiring. I interpreted his remarks to mean that there might be an overload problem in the electrical wiring system.

Would you agree that there is a need to replace the wiring or that there might be an overload problem, and would that constitute fire hazard in your opinion?

**Mr. Barnes:** Well, there is an overload problem in the sense that, as Mr. Suttis mentioned, the equipment used nowadays takes a hell of a lot of power, and we do not have adequate power in some cases to carry these things. So, depending on where a piece of equipment may be plugged in, it may trip a breaker or blow a fuse. There is an overload problem in that sense.

I am not convinced that because breakers are tripped or fuses are blown periodically the overload problem constitutes a fire hazard. No, I am not. Some of the wiring is older than other parts, and it seems like a normal precaution that when something becomes of a certain age, you take steps to have it replaced as a matter of course. You would do the same in any other facility. Even if that wiring is judged to be entirely sound you say, "That wiring is 40 years old, so it

is perhaps about time we thought about replacing it."

**Mr. Pope:** Have you, in the course of your duties, inspected the wiring system in the buildings?

**Mr. Barnes:** It is not my job to crawl through places and inspect it to that extent, no. I only know what I have seen on other occasions when it has been mentioned.

**Mr. Pope:** On a number of items that I just asked you—

**Mr. McClellan:** One supplementary, just going back for a second to Cumberland House. What was Cumberland House used for? Am I correct in understanding that it was used by the Ministry of Community and Social Services?

**Mr. Barnes:** Yes, the Cumberland House building presently is occupied by children who use the facility as a school. They are under the auspices of Community and Social Services and they are taught by teachers brought in from the Etobicoke Board of Education.

**Mr. McClellan:** Is that facility staying there? The Community and Social Services' program that is running at Cumberland House—is that staying there?

**Mr. Barnes:** They are, I should say, during normal school hours.

**Mr. McClellan:** That is not part of the—

**Mr. Lawlor:** Of the closing?

**Mr. McClellan:** Of the closing, is it?  
Interjection.

**Mr. Barnes:** No, we do not know anything. All we know is what we hear in the usual scuttlebutt sense.

Interjection.

**Mr. Lawlor:** We have asked him but he says he does not know; it is in ComSoc. It's not his baby.

**Mr. Barnes:** We have heard that no suitable facility has been found, whatever.

**Mr. McClellan:** That was part of the adolescent—it was moved into the children's services division.

[4:30]

**Mr. Barnes:** Our building, cottage five, is occupied by these children under ComSoc and they also used this Cumberland building as a school—strictly normal school hours during the day.

**Mr. McClellan:** I see. Thanks; okay.

**Mr. Pope:** We have been through a list of things, and some of them you mentioned you had asked for. Was there some ongoing



discussions you had with Mr. Suttis about the costing of these various items? Did you bring these items to his attention?

**Mr. Barnes:** It is very hard to say because we work very closely. Some items he may have brought to my attention and some I may have brought to his attention. As far as costs go, it never really mattered to me. If I thought something was necessary and mentioned it, and perhaps I did not hear anything for what might seem to me some length of time—I tend to be a little on the impatient side—I would mention it again.

It did not seem to matter how much it would cost. The only time I would find out how much it cost is if it got to the stage where we would have a meeting with the appropriate people from the Ministry of Government Services, when we would get down to exactly what equipment would be required to carry out this function and how much it was going to cost and what we would have to do to accommodate it, and all these other details. Then I might become aware of just what I had asked for.

**Mr. Pope:** In your meetings with the Ministry of Government Services, was there ever any discussion about the electrical system and whether or not it was felt to constitute a fire hazard?

**Mr. Barnes:** I personally did not have discussions with the MGS on electrical. What I will say is that we would sometimes say things in order to embellish our need for something.

**Mr. Pope:** Do all of these things taken in their totality—the things we have just talked about and perhaps the problem which led to the replacement of the electrical system—give you cause for concern as to the fire safety of Lakeshore?

**Mr. Barnes:** I feel about them in the way I feel about the tiles. I feel that these things are necessary; some other things that were discussed were necessary. We sometimes came across something that had not entered our minds before, but in the course of an inspection or an actual alarm or evacuation or something we might find it would really be good if we could do this or get that or change the system some way; so we think it would improve. You can never be absolutely perfect.

These things come up that we think would improve our status and we see about what we can do about getting them done. But I have not really seen anything that I would have to come down here on my hands and knees and beg for it because, “My God, something terrible is going to happen if this

does not go in in the next two weeks.” So I was a little flabbergasted at the comment.

**Mr. Pope:** Do you file requisitions or reports on fire safety requirements of Lakeshore with anybody on some sort of regular basis?

**Mr. Barnes:** Not specifically requirements. I file reports on a fairly regular basis to my superior on any of my activities since the last report in the way of fire safety. And that could include anything. It could include something wrong I have found; what I have done to correct it or what needs to be done to correct it if I can't do it myself; whatever alarms have taken place; whatever instruction has taken place; and any activity whatsoever such as inspection of buildings or equipment, by myself and by those from Ministry of Government Services who are responsible for maintaining some of that equipment; I make the comment that it has been done by them. I don't come along every month and say, “Here is a list of things we need for fire safety around here.” I make a report on it as soon as it comes to my attention. I don't wait because I have to report monthly or weekly or anything. If something comes to my attention today I'll go and investigate it and I'll make a report on it tomorrow. I could make a report on something else the following day if it arose.

**Mr. Pope:** Would any reports be filed with you concerning any problems with the electrical wiring system? Would it be reported to you?

**Mr. Barnes:** If I have anything in writing, it's probably a copy of correspondence between the other people involved. I am not involved with MGS on that basis. If I don't have it in writing then I certainly would know about it because of verbal discussions.

**Mr. Pope:** Right. Have you had any such discussions?

**Mr. Barnes:** No. I know it is being considered that the electrical system was a fire hazard, and I think I said perhaps why it would be stated that way. I am personally not of the feeling the electrical system is a fire hazard. I can't recall a fire in that facility which was caused by the building, the environment. They are not caused by the fact the building is old or the building is new, or whatever, at all.

**Mr. Pope:** I am just trying to understand it. This is my last question, and I thank you very much for your help. I am just trying to understand. I often hear overloading and old wiring in a building can constitute a fire hazard. Are you saying that's not true?



**Mr. Barnes:** What I am saying is the wiring is in conduit, or it's in a metal raceway of some kind. If a housekeeper comes along and plugs in a 14-amp floor polisher, and there are several lights on that circuit, the lights all go out, and the breaker trips. If, by some means or other, there was a small portion of wire in that circuit somewhere where the insulation cracked and fell off, then it would probably touch the raceway and trip the breaker on its own, as soon as somebody flicked on a light.

I doubt very much, in fact, if at any time you are going to suddenly find somewhere in a wall space or in an attic, or God knows where, a fire was going to occur simply because a piece of electrical wire was hot. We hear about this in our own homes, but our own homes are different.

**Mr. Pope:** Something I forgot: you mentioned it's been said the electrical system constitutes a fire hazard. Who said that to you?

**Mr. Barnes:** I have heard it said by people from MGS, just in conversation.

**Mr. Pope:** Thank you, Mr. Chairman.

**Mr. Chairman:** Mr. Johnston.

**Mr. R. F. Johnston:** I won't keep you more than a minute or so. You've been fire safety officer for nine years, did you say?

**Mr. Barnes:** For about a month short of nine years, yes.

**Mr. R. F. Johnston:** It's policy, as I understand it, to have just one person involved in the fire safety program in most stations like yours, isn't it?

**Mr. Barnes:** For quite a long time the chief engineer of these facilities seems to have been the fire safety officer.

**Mr. R. F. Johnston:** During the nine-year period and before, if you want to comment on it, I presume you received a number of updates on fire safety, officially from people like fire prevention officers and the Ontario fire marshal's office and also from organizations having to do with fire safety which sent out bulletins and that sort of thing. Would you say that you have noticed continual and consistent changing standards during that period of nine or 10 years?

**Mr. Barnes:** Standards are always upgraded. That's one of the things that bothers me when it has been said that that facility is substandard. It's substandard as to what and to when, I have wondered.

**Mr. R. F. Johnston:** That's exactly the point I am trying to raise. Is it not possible

with the concern that rose in the last year and a half about the fill for cushions and mattresses and the business of finding that a lot of the ceiling tiles put in in the early 1950s and 1960s were flammable, that there are likely to be other kinds of occurrences like this in the future, and that if the fire marshal came in next week, after discovering this in some other area of the province, they would then ask you to gradually change over that sort of thing?

**Mr. Barnes:** If word came out tomorrow, notwithstanding the closure, that they'd finally come up with standards for furniture and if the fire marshal said that these were the standards and that there was entirely adequate ultimate stuff available, then the first thing we would do is make this available to management and then get into the program of getting rid of this furniture, as we did with mattresses after reading about a few of those bad occurrences with those.

**Mr. R. F. Johnston:** At the end of your discussion with Mr. Pope, you finally answered the question I would have posed to you about the way the whole circuit breaker system works, the conduiting and that sort of thing and why there isn't a particular immediate fire hazard from wiring. It seems to me that one of the other major areas that is being focused on tends to be the administrative building and the problems there. I find it somewhat ironic that it's concern with the fire safety in that building that the ministry has at a time when it is willing to allow a person to go who has had 21 years of employment with the ministry. That's an interesting kind of dichotomy.

Cumberland House, which is something used during the day and not by psychiatric patients, is another interesting example to raise in my opinion. I would just say that your response at this point, I am sure, could be confirmed by the Etobicoke fire department and that the Ontario fire marshal's office will show that standards are up to date there. I would just like to thank you very much for your participation.

**Mr. Chairman:** Thank you, Mr. Barnes. We appreciate your attendance.

**Mr. Morin,** the administrator of the Hamilton Psychiatric Hospital, is from out of town and I think he would like to get away soon.

**Mr. McClellan:** Did you want to go first, Mr. Lawlor?

**Mr. Lawlor:** Yes, I wanted to make some acerb statements—not absurd, acerb. They are quite different things really.

At the initiation of this thing when the first clarion call for closings took place, Hamilton was not part of the deal. As a matter of fact, that was the case even with Whitby to any extent. It was all Queen Street. Then by declension the ministry found itself, I suggest, in some difficulty with respect to its figures and with respect to its projections and included Whitby. Having found that inadequate, the ministry then proceeds to encompass Hamilton. It throws it in for good measure.

[4:45]

Curiously enough, what has happened now is that the statement made by the minister in this committee for the first time, last Monday, makes Hamilton monumental. It is a central figure now. It is the answer to most of his problems. This is very sudden, very curious. Certainly, when they launched their McKinsey hearing—I take it, good doctor, you've heard of the document—Hamilton was not ventured as portion of this picture at all. In order to give some kind of bolster, some kind of cement to the case, they ranged out beyond the major document which we have under study and which is our guiding point—and for which, by the way, we are enormously grateful.

Most of the time on these inquiries, we do not have adequate documentation, indepth analysis, or things to our hand on which we can base a penetrating analysis. In this case, curiously enough, we have. Lawyers, you know, go into court most often without that kind of full and plenary background. They so seldom have it. When you go in to a workman's compensation case, you don't have the plenitude of fact and information that would be necessary. That is just a statement. I don't expect an answer.

I think the game the ministry is playing is fast and loose. There is a great deal that is invidious in all this and I wish the minister would stop playing his damn games. He has come up with, as the overflow or conduit pipe or relief vehicle, 100 beds in your hospital.

Mr. Marin: Yes sir.

Mr. Lawlor: How many people have you accepted this far?

Mr. Morin: So far, we have received five patients from Lakeshore.

Mr. Lawlor: Some of those patients had to be turned back, doctor; is that correct, doctor?

Mr. Morin: One point of correction, Mr. Lawlor. I am not a physician.

Mr. Lawlor: Oh, I'm sorry.

Mr. Morin: Did you ask if we turned back some people?

Mr. Lawlor: Do you consider yourself moved or is that a penalty?

Mr. Morin: I don't know. You asked if some patients were returned.

Mr. Lawlor: Yes.

Mr. Morin: I don't believe so.

Mr. Lawlor: They were sent from Lakeshore and were turned back and returned to Lakeshore—

Mr. Morin: Not to my knowledge.

Mr. Lawlor: —on the basis, as I understand it, of the residence requirements, or something of that kind.

Mr. Morin: No sir, not to my knowledge.

Mr. Lawlor: Not to your knowledge.

Mr. Morin: No sir.

Mr. Lawlor: Have you been given any indication from the ministry as to what inpatient load you may anticipate through the Lakeshore?

Mr. Morin: My brief discussions with Lakeshore indicated that last year they admitted approximately 51 patients from the Halton region who, had they been in our area, we would have admitted at that time.

Mr. Lawlor: That is the southern-east portion.

Mr. Morin: That is correct.

Mr. Lawlor: Which is now, according to the redefining of boundaries, being allocated to Hamilton.

Mr. Morin: That is right.

Mr. Lawlor: You wouldn't think you would extend your demesne beyond that to the west at all or take any portion of Peel.

Mr. Morin: No sir, not according to my instructions.

Mr. Lawlor: I still have the same question. Have you been given any indication of the precise number of people who would be taken from Lakeshore, whether they are within that geographical area or not, in order to relieve or in order to empty the hospital?

Mr. Morin: No sir.

Mr. Lawlor: Your understanding would be that the overwhelming bulk of these patients would be going to Queen Street.

Mr. Morin: As far as I know.

Mr. Lawlor: Have you been consulted about that at all?

Mr. Morin: No sir.



**Mr. Lawlor:** So pretty much from here on in, whether Queen Street becomes overloaded or not and can't contend with the particular problems, you would anticipate remaining within your own confined geographical area, period.

**Mr. Morin:** That's what I've been told so far.

**Mr. Lawlor:** Correct me if I am wrong—which you would do; no matter—is it true that the hospitals, including the Hamilton Psychiatric, because of area councils, health councils and regional councils, object to being a depository, if I may put it that way, with respect to other regions?

**Mr. Morin:** I don't quite understand your question.

**Mr. Lawlor:** If, in some area that is not within your defined catchment area, someone seeks to send a doctor or another facility seeks to send a patient to your hospital, my understanding is that you have severe objections to them taking in these extra-territorial cases.

**Mr. Morin:** Generally speaking, it is far better for the patient if he is in an area with which he is familiar and where his friends and relatives are. We do have special programs in Hamilton in which we accept people from different parts of the province.

**Mr. Lawlor:** Name a couple of them.

**Mr. Morin:** We have a social and vocational rehabilitation program in which we have received some patients from Thunder Bay and the Ottawa area.

**Mr. Lawlor:** I am going to explore that for a moment. That program I take it is very similar to one located on the Lakeshore grounds at present—the trades and rehabilitation program.

**Mr. Morin:** I don't believe so, sir.

**Mr. Lawlor:** Are you acquainted with the Lakeshore operation?

**Mr. Morin:** Not in the last four years.

**Mr. Lawlor:** I see. All I am doing is seeking to explore why you would take people from Thunder Bay.

**Mr. Morin:** We have physicians who have requested us to take patients from there because they had heard we had a specialized unit that would be helpful to their patients, and so we will take them if we feel we can be of some help.

**Mr. Lawlor:** I am sorry, Mr. Morin, why is it so specialized as that?

**Mr. Morin:** Why is it specialized?

**Mr. Lawlor:** No, what is the special service provided that would attract this particular kind of allocation?

**Mr. Morin:** This is a particular program. As I have stated to you before, Mr. Lawlor, I am not a physician but I will try to give you what I know about it. It's a behaviour modification program which has been at the hospital for the last three or four years and has been quite successful with younger schizophrenics. When the word gets around that we have been somewhat successful with this, other physicians hear about it and they would like to refer certain patients to us.

**Mr. Lawlor:** On your understanding, Mr. Morin, this particular program is unique to that hospital and is not duplicated anywhere else?

**Mr. Morin:** I can't say that it's not duplicated somewhere else, I do not know.

**Mr. Lawlor:** Particularly in the Toronto region or at the Lakeshore hospital. It's a behaviour modification program that is separate and distinct.

**Mr. Morin:** Some special types of it.

**Mr. Lawlor:** You have perused the McKinsey report?

**Mr. Morin:** Briefly.

**Mr. Lawlor:** What is your opinion?

**Mr. Morin:** My opinion of the McKinsey report? Well, the report is a study that was completed, given to the ministry as a recommendation, and it's up to the ministry to make that decision.

**Mr. Lawlor:** Oh, you don't care to make any personal comments or to assess its validity or anything like that?

**Mr. Morin:** I am not sure if I am competent to do that.

**Mr. Lawlor:** All right. That's fair enough.

**Mr. McClellan:** Mr. Morin, I wanted to ask you just a couple of questions with respect to the 1978-79 operational plan for Hamilton Psychiatric Hospital which I understand you submitted to the ministry in March 1979. Is that a document that is familiar to you?

**Mr. Morin:** Yes, sir.

**Mr. McClellan:** I was just wanting to get a sense of your bed space; the material that you deal with on page five of part two, "Current Level of Service," from your report. Your total number of rated beds in the hospital is 544, is that correct?

**Mr. Morin:** That's right, yes.

**Mr. McClellan:** The present bed setup is 443. You have a total of 98 unallocated beds—30 in Century Manor, 20 in D2 and 48



in C2. What I don't understand is the relationship between those 98 unallocated beds and the other two figures—your rated capacity and your bed setup. Would those 98 beds be deducted from the total rated beds?

**Mr. Morin:** Yes sir.

**Mr. McClellan:** So 544 less 98 gives you roughly—we lose a couple of beds somewhere in the transition; I think we lose four beds somewhere—but deducting the 98 unallocated beds from your total rated bed capacity of 544 gives you your present bed setup of 443. Out of the 443 beds that are set up, are they filled to capacity? Is every bed occupied, or what is the occupancy rate of the beds that are set up?

**Mr. Morin:** As of today or yesterday our occupancy would probably be 370 to 375 patients. However, we always have an additional 40 or 50 beds that are allocated to patients who have not been discharged from the hospital but have been sent home for a week or two weeks and might be coming back at any time.

**Mr. McClellan:** What would be the occupancy rate over the last six months, including the 40 or 50 beds that you have set aside?

**Mr. Morin:** Approximately 82 per cent.

**Mr. McClellan:** Have you sat down and tried to figure out what your capacity is to accommodate patients from the present Lakeshore catchment area?

**Mr. Morin:** The figure I have been given from Lakeshore is 51 for the portion of Halton county that we would be accepting responsibility for. Fifty-one patients for the year would mean an average of one a week. I think there would be no difficulty in handling that at all, or even the population growth within the next year or two, which certainly would not increase that greatly.

**Mr. McClellan:** So you can cope over the next couple of years, this is what you're saying?

**Mr. Morin:** Right.

**Mr. McClellan:** When you're talking about coping, does that mean you would have to alter your plans to use Century Manor or the C2 or D2 ward?

**Mr. Morin:** Not at the present time.

**Mr. McClellan:** So your sense is that you can pick up a share without having to compromise the program plans?

**Mr. Morin:** Correct.

**Mr. Ramsay:** Mr. Morin, I understand one of the issues at Lakeshore has been the pending closure of the special observation unit. I also understand a similar unit

was closed at Hamilton about nine months ago. I was wondering if you could tell us the effects that the closing of this unit had on the patients and staff, and your general observations?

[5:00]

**Mr. Morin:** Yes, I would be happy to. The situation at Lakeshore, as I heard the comments made today, is not the same type of a unit as the one we had at Hamilton. The unit we had at Hamilton was composed of 11 or 12 beds and was used primarily to receive patients from the courts who had been referred to us on warrants of remand, which can be 30 or 60 days. Those patients are then, at the end of that time, returned to the court. They were not put in there because they were violent or for other reasons but purely because they were what we would refer to as forensic patients.

The unit was closed approximately a year ago. It did cause some consternation at the time, but I can honestly say that we have not had major difficulties with it. One or two courts would probably prefer to have more security than we can offer for their patients, but outside of that I cannot state that we have had major difficulties.

**Mr. Ramsay:** What was the alternative when this was closed? What happened to this type of patient?

**Mr. Morin:** Two beds were allocated to four wards and we reduced the number to eight beds altogether from the 11. The reason it was reduced was that we were never running 11 patients at a time. Our average occupancy in the forensic unit was six or seven patients on a yearly basis.

**Mr. Ramsay:** I see. Thank you very much.

**Mr. Chairman:** Mr. Conway?

**Mr. Conway:** Yes, Mr. Chairman, one question: Much has been said and on two occasions, initially on January 22 and more recently on Monday of this week in this committee, the minister stressed the government's concern about and commitment to reassigning and relocating as many people as possible from the Lakeshore site within the Ontario public service.

We've heard testimony from at least four people. Two in the administrative or professional class have indicated they have been offered reassignment, one in Whitby and one in Queen Street. But, most alarmingly, we heard today from two very senior people at Lakeshore who I suspect fall into neither category but whose long service is clear and outstanding, both of whom were clear in

indicating that they sensed nothing was being done about their future employment.

Might I ask you, sir, whether or not at any time since January 22 you or your staff has been approached from the Ministry of Health with a view to the possible acceptance on your staff, now or in the near future, of some people now employed at Lakeshore Psychiatric?

**Mr. Morin:** We have been informed by the human resources branch that, when any vacancy occurs in Hamilton Psychiatric Hospital, prior to filling those vacancies they have to be posted at Lakeshore so that anyone at Lakeshore who could qualify for the position in this particular field would have the opportunity and would be given the first opportunity, if possible, to fill that position.

**Mr. Conway:** Beyond that, nothing in particular?

**Mr. Morin:** Not to my knowledge.

**Mr. Conway:** How long have you been at the Hamilton Mental Health Centre?

**Mr. Morin:** Four years to last March.

**Mr. Conway:** In the last year how many staff positions, professional and nonprofessional, have been vacated at your facility?

**Mr. Morin:** I can't answer that off the top of my head, sir.

**Mr. Conway:** What's the total staff complement?

**Mr. Morin:** We have 747 allocated complement.

**Mr. Conway:** And you can't give me any indication of how many job openings have occurred at that facility in the last year?

**Mr. Morin:** It's a constant thing. As I say, rather than give you a bad figure I've got to say I don't know. We have people who leave for a variety of reasons; we have other people that retire; and there are always one or two deaths during the course of a year.

**Mr. Conway:** Prior to the Lakeshore closing, was there any pressure or any policy from the human resources branch to facilities such as your own with a view to giving prior consideration to people from other hospitals within the Ontario jurisdiction? Or is this latest directive something reasonably new?

**Mr. Morin:** No, this just occurred because of the conditions at Lakeshore—

**Mr. Conway:** The Lakeshore closing.

**Mr. Morin:** The closing of the Lakeshore hospital, because prior to that—well, I must back track a little bit. There was something that came up recently where a teachers' college or something in Hamilton was closing

and we were advised to take that into consideration, but outside of that that is all.

**Mr. Conway:** To the best of your knowledge have you hired anyone at the mental health centre from the closed teachers' college in Hamilton?

**Mr. Morin:** Not that I know of. That does not mean that we have not hired a secretary or someone.

**Mr. Conway:** Thank you very much.

**Mr. Duksza:** Mr. Morin, let me just clarify a couple of things about the bed capacity. This, I think, comes from you. Your present bed setup is 443, right? You have now 375 patients?

**Mr. Morin:** Yes.

**Mr. Duksza:** How many do you allocate for the people who are in the community in approved family homes? How many do you allow for that?

**Mr. Morin:** We allow, I would say, roughly 50.

**Mr. Duksza:** Roughly. So it would bring it to 425.

**Mr. Morin:** Maybe 440; probably 60 out of that. It would be about 430-something.

**Mr. Duksza:** About 430? Well, 443 minus 30 would leave 413 beds. One of the alternatives that has been discussed when the Lakeshore hospital is closed is that you may have to take—more significantly—not only people from the areas which are allocated to your catchment area but the area may have to be bigger and you may have to take more. Where would you put them? Supposing there were 100 people that had to be transferred, where would you put them?

**Mr. Morin:** We have 98 unallocated beds.

**Mr. Duksza:** Now, are those beds actually set up at the moment or are the wards closed? How does it operate?

**Mr. Morin:** I would guess that with probably three or four days of setting beds up, it can be done. The space is there.

**Mr. McClellan:** By way of supplementary, that would mean you would have to cancel your program plans for a forensic program at Century Manor and for relocating programs into the C2 ward from buildings which, as your report says, should be demolished. So that is the choice you have.

We are just trying to understand what choices are confronting you. If you took those 100 beds and made them available for Lakeshore, you would have to cancel your planned forensic program. You would have to keep patients in buildings which, in your view, should be demolished.



**Mr. Morin:** That would be right, yes.

**Mr. Duksza:** It would be, in fact, rather difficult to do. Would you have to double up in some wards and put in extra beds, or is it merely that you would have to cancel some of the programs and some of your plans?

**Mr. Morin:** The 48 beds in C2 could be opened in a matter of days.

**Mr. Duksza:** And you have staff for all that or will the staff have to come from Lakeshore?

**Mr. Morin:** Well, that we would have to negotiate. I do not have the staff to handle 100 patients.

**Mr. Duksza:** You haven't?

**Mr. Morin:** Not an additional 100, no.

**Mr. Duksza:** Yes, that is one of the points I wanted to establish.

The other thing is, are you satisfied with the present catchment area or do you consider that it should be extended?

**Mr. Morin:** Am I satisfied with what?

**Mr. Duksza:** Do you think that the catchment area that Lakeshore Psychiatric Hospital has now is a reasonable one or should it be extended?

**Mr. Morin:** No, I would think that with the new responsibility we have been given it is reasonable for us.

**Mr. Duksza:** And your new responsibility involves what? Half of Halton county?

**Mr. Morin:** No, we had half of Halton and now we have all of it.

**Mr. Duksza:** I see. I think someone else has asked this question, but I was not here: How many patients would you be admitting from that area?

**Mr. Morin:** From that particular area 51 patients were admitted to Lakeshore last year.

**Mr. Duksza:** Last year.

**Mr. Morin:** That is what I have been told.

**Mr. McClellan:** This is a supplementary: Assuming that holds and you have now 51 new patients over the coming year coming into Hamilton Psychiatric Hospital from that new catchment area, do you have the staff to cope with that now? Or would you need additional staff to cope with that additional—

**Mr. Morin:** Fifty-one?

**Mr. McClellan:** Fifty-one.

**Mr. Morin:** No, nothing for the 51.

**Mr. McClellan:** You would need additional staff to deal with the additional 51?

**Mr. Morin:** No.

**Mr. McClellan:** Oh, you would not?

**Mr. Morin:** No sir. We would for the 100 that Dr. Duksza mentioned.

**Mr. McClellan:** Once you move into the unallocated beds, then you are talking about an increase in staff.

**Mr. Morin:** That is correct.

**Mr. Duksza:** You are the only one who has come here from Hamilton Psychiatric Hospital. What is the general feeling about enlarging the size of the hospital among the people who presumably set up the policies about extending its catchment area? What is feasible and what is not feasible, in the opinion of you and other people at the hospital?

**Mr. Morin:** It hasn't really been discussed, sir.

**Mr. Duksza:** May I ask why not? Why has this not been discussed? I mean it seems like an important part of an enlargement of the responsibility of a hospital when you are given potentially another 100 patients and your catchment area gets enlarged.

**Mr. Morin:** I would like to look at it from the point of view that the difficult things would take a little while to do and the impossible takes a little bit longer. We would adjust to the situation.

**Mr. Duksza:** By impossible you mean in terms of your capacities as a hospital to deliver a good therapeutic service.

**Mr. Morin:** If we had the additional staff, yes, sir.

**Mr. Duksza:** You would have to have an additional staff?

**Mr. Morin:** For the 100 patients that you are talking about, yes.

**Mr. Duksza:** Well, it's just one of the ways of solving the potential problem of the closing of Lakeshore. They would have to go somewhere, I mean, even if it means trouble for everyone else concerned.

**Mr. McClellan:** I would like to have a little bit of detail about the forensic program you are planning to put within the 30 unallocated beds in Century Manor. There is a forensic program already at Hamilton Psychiatric Hospital?

**Mr. Morin:** Yes, we had a forensic unit with 11 beds at one time. As I answered the gentleman a few minutes ago, the unit was closed because we did not have the staff, we did not have the funds and we had to make some other adjustments. What is being proposed in that operational plan is something in the future; if we had funds we could not only do forensic assessments



for the courts but possibly we could do some forensic treatment for them.

**Mr. McClellan:** We well remember the unfortunate closing of the old forensic unit. Is there a forensic program anywhere in Hamilton at this point?

**Mr. Morin:** We still render forensic services and assessments, but it's on a decentralized basis.

**Mr. McClellan:** Right. Thank you. And in terms of the stated intention within your 1978-9 operational plan to use the C2 ward, which has 20 of your 98—what's the word, unallocated?

**Mr. Morin:** Unallocated.

**Mr. McClellan:** Unallocated beds. Your plan is to move programs into that ward which are presently, in the words of the report, "dispersed in buildings located on the grounds that should be demolished." Why should these buildings be demolished?

**Mr. Morin:** They are not housing patients at the present time; they are used for activity rooms, and they are former residential homes of employees, physicians and superintendents of 100 years ago or so.

**Mrs. Campbell:** They're historic.

**Mr. Morin:** Yes, the most historic one has disappeared, though. That was the Barton building, which was demolished two years ago.

**Mr. McClellan:** So that was 48 beds rather than 20—

**Mr. Duksza:** I have just one more question—that was all supplementary.

**Mr. McClellan:** Forty-eight beds in C2 and—

**Mr. Morin:** Forty-eight, 20 and 30.

**Mr. Chairman:** The supplementaries are longer than the main questions.

**Mr. McClellan:** Right. And 20 for a special program for schizophrenics.

**Mr. Morin:** Right.

**Mr. McClellan:** Would these be new programs?

**Mr. Morin:** No, sir.

**Mr. McClellan:** These would be putting the existing programs for schizophrenics in more suitable accommodation?

**Mr. Morin:** Correct.

**Mr. McClellan:** Thank you very much.

**Mr. Duksza:** Do you have an infirmary or, when there is a major physical problem, do you put people in the other . . .

[5:15]

Interruption in recording.

**Mr. Duksza:** —actually not available while the minister thinks they are available.

**Mr. Morin:** I can't tell you in any particular day.

**Mr. Duksza:** The minister probably doesn't know either, but at least I would like to know whether these were considered or not.

The other thing is, do you have a psychogeriatric unit?

**Mr. Morin:** Yes, sir.

**Mr. Duksza:** What is the occupancy rate there? Is it part of the total general hospital beds or is it treated separately?

**Mr. Morin:** It's part of the overall complement of the hospital. It's a separate unit, just like you'd have a surgical unit or—

**Mr. Duksza:** So there is a difference between infirmary beds and the psychogeriatric unit beds? Those are part of the general complement of which you can say there are so many vacancies while for the infirmary really you cannot say that. You couldn't include them in the whole complement. Am I correct?

**Mr. Morin:** That's correct. Right.

**Mr. Duksza:** That's it, Mr. Chairman.

**Mr. R. F. Johnston:** It's obviously a matter of seniority—the supplementaries were also my questions in most cases.

**Mr. Conway:** You are learning very quickly.

**Mr. R. F. Johnston:** I'm very astute that way.

There are a couple of items of information I'd like to know. What is your admission rate? What was it last year?

**Mr. Morin:** We had an increase in admissions last year for a period of time, but it started to drop off towards the end of the year and it's back to normal. I'd say roughly about 900 a year; 75 to 80 a month.

**Mr. R. F. Johnston:** And what's your average rate of stay?

**Mr. Morin:** Approximately six weeks to two months.

**Mr. R. F. Johnston:** Two months. Okay.

There was something Mr. Lawlor was alluding to which I wasn't really clear about from your answer. That was to do with your relationship with the health council in your area. Does the representation on that health council encompass all the Halton area?

**Mr. Morin:** The health council that is effectively working in Hamilton is called the Hamilton-Wentworth District Health Council. There is another district health council called Halton, which is a separate situation altogether.

**Mr. R. F. Johnston:** I am just trying to think of other areas there like the Durham region, where policy in the mental health field now is cleared through the health council; I was active on its subcommittees to do with mental health. Has your hospital a relationship with each of the health councils in your area? Does it have representation on committees of health councils?

**Mr. Morin:** We have a continuing liaison with each one of those district health councils. Our liaison with the one in Hamilton is quite active because of its location. The physicians at the hospital are on various health committees, service committees; I participate in the administrative committees, and that kind of thing.

**Mr. R. F. Johnston:** Has there been any interaction about this decision to have the extension into the rest of Halton between yourself and either of these health councils or from the ministry through them to you?

**Mr. Morin:** No, sir.

**Mr. R. F. Johnston:** They have not been involved in that decision at all?

**Mr. Morin:** They are aware of it, but there has been no question of whether we could or couldn't extend.

**Mr. R. F. Johnston:** And they haven't expressed an opinion to you one way or another?

**Mr. Morin:** No.

**Mr. R. F. Johnston:** Thank you very much.

**Mr. Chairman:** Thank you very much, Mr. Morin.

**Mr. Lawlor,** do you have a further question?

**Mr. Lawlor:** Yes, just a couple of questions. Your admission rate in 1977 was 736; in 1978 it was 916. Would those figures be accurate?

**Mr. Morin:** Yes, they are, sir. They went up last year, as I indicated when I answered the previous question.

**Mr. Lawlor:** Yes, they went up quite a bit, and then you say they declined towards the end of the year?

**Mr. Morin:** It's gone back down this year, and I don't know why.

**Mr. Lawlor:** Have you any studies with respect to population projections and to what your situation on admissions might be four or five years hence?

**Mr. Morin:** Studies have not been made on that, Mr. Lawlor. We only can look at the population growth to give us some indication

and that doesn't appear at this point to be very monumental.

**Mr. Lawlor:** Let me return just for a moment to the forensic.

**Mr. R. F. Johnston:** I wonder if I might ask a supplementary. It's on the matter of admissions, and you say they're going down. But your own projections for 1979 and 1980 lists it as going up about 200 in your estimation. Is that prior to your realization they were going down?

**Mr. Morin:** Based on what was happening last year when we were making out this operational plan we said maybe something is happening and it's going to start going up and we had better start thinking a little bit because there was a minor population growth predicted. Then when we saw this was happening we said probably it will increase, but for the first two or three months of this year it's gone back to what it was doing, so probably my projections for this year and next year may be all wrong.

**Mr. Lawlor:** Do the courts in the Hamilton area rely exclusively upon the Hamilton Psychiatric to bring in patients and for the assessment of the Lieutenant Governor's warrant?

**Mr. Morin:** You're talking about the warrants of remand?

**Mr. Lawlor:** Yes.

**Mr. Morin:** Yes.

**Mr. Lawlor:** None of these people are referred to Penetang or anywhere else?

**Mr. Morin:** Yes, some of them have been because of the nature of the case.

**Mr. Lawlor:** Are they referred back to you?

**Mr. Morin:** No, they go back to the court directly.

**Mr. Lawlor:** What kind of security obtains at the hospital with respect to these patients?

**Mr. Morin:** Most of our wards have locked sections. The wards where these patients are located are divided approximately in half, and half can be locked and half left open. When we have forensic patients on the warrants of remand we keep them in a locked section. That doesn't mean they don't sometimes try to get out; we've had a few who have left.

**Mr. Lawlor:** Have got out?

**Mr. Morin:** They were getting out of the other forensic unit too. If anybody wants to get out, he can get out.

**Mr. Chairman:** Celia Royce, president of the Lakeshore Volunteers Association, is next.



I believe we have a brief from you as well, do we not?

**Mrs. Royce:** Yes.

**Mr. Conway:** Before we proceed with this witness, I am wondering whether or not, the hour being what it is, we might just order our affairs to the end of this period. I don't know what the wish of the chair is. It is my understanding that we have this witness, someone from the Community Resources Consultants, am I correct?

**Mr. Chairman:** Yes.

**Mr. Conway:** Is it expected that we will get to where we will even want to begin with people who I believe are also here from the Queen Street Mental Health Centre?

**Mr. Chairman:** I would think, Mr. Conway, if we can deal with Mrs. Royce and Mrs. Best, that would be all we could possibly hope for today. I presume the Queen Street people will take considerable time and I see no point in moving into that today—indeed I don't think we will have the time. I just hope we can finish with Mrs. Royce and Mrs. Best because I think they were here yesterday and we don't want to inconvenience them further by bringing them back again.

**Mr. Conway:** My point in raising the matter was a similar one: if there were people here from the Queen Street Mental Health Centre I didn't want to unduly inconvenience them by holding them any longer. It is my understanding we would not have time to get to them today.

**Mr. Chairman:** Is Mr. Fisher here?

**Mr. Fisher:** Yes.

**Mr. Chairman:** Dr. Anderson?

**Dr. Anderson:** Yes.

**Mr. Chairman:** Mrs. Latimer? And Mrs. Jones?

**Mrs. Royce:** She left.

**Mr. Chairman:** I see. I think as far as the people from Queen Street are concerned, obviously we won't get to you today. We don't want to inconvenience you further by keeping you here if you wish to leave. We'll have to reschedule you if that's convenient. We have Dr. Rzadki and Mr. Sean O'Flynn and Mr. Bob De Matteo slated for Monday. I am wondering if the committee would want to block the Queen Street people in on Monday and perhaps reschedule the other people. What does the committee wish?

**Mr. Conway:** From my vantage point, Queen Street would be very appropriately slotted for Monday.

**Mr. Lawlor:** I would agree with that.

**Mr. Chairman:** Is that the wish of the committee? Okay. Would that be convenient to the Queen Street people, Mr. Fisher? Would Monday be okay?

**Mr. Fisher:** Yes.

**Mr. Chairman:** Dr. Anderson?

**Dr. Anderson:** At what time on Monday?

**Mr. Chairman:** Mr. Fisher would be on first, so in terms of your appearance I would think 4:15 or 4:30 or thereabouts, and Mrs. Latimer and Mrs. Jones after that. Would that be convenient? Okay, we'll do it that way. Thank you very much and I'm sorry for the inconvenience.

**Mr. Fisher:** Mr. Chairman, what time will it start on Monday?

**Mr. Chairman:** After routine proceedings, which is normally around 3:15 or 3:30. If you're here at 3:15 I think that would be adequate.

**Mr. Conway:** Mr. Chairman, just one or two brief questions for Mrs. Royce. Could you indicate very briefly the nature of your association in terms of its membership and mandate?

**Mrs. Royce:** We have approximately 275 to 300 volunteers and we have been working at the hospital for 20 to 25 years.

**Mr. Conway:** Working in almost all facets?

**Mrs. Royce:** Yes, we have worked in some 30 services around the hospital.

**Mr. Conway:** Among the principal questions this committee has to consider is that dealing with the state of community resources and community mental health services that have been long associated with Lakeshore, and whether or not these community-based mental health services can possibly be expected to continue if that facility is closed. Could you offer a comment in that connection from your point of view, notwithstanding your brief, what you feel to be the likelihood of the effect of the closure of the Lakeshore hospital upon the continuation of and the quality of those community-based mental health services?

**Mrs. Royce:** You mean as far as the volunteers are concerned?

**Mr. Conway:** The volunteers and the part they play in those programs.

**Mrs. Royce:** As everyone else has said, having a base is very important. I think we as an association would lose our effectiveness if the hospital were closed. Certainly we would have to have some other charter or



name, or whatever. We would be spread, dispersed.

[5:30]

**Mr. Conway:** There would be particular difficulties, I would imagine, just in logistical terms, in dealing with Queen Street from your point of view?

**Mrs. Royce:** Yes. We have a lot of our volunteers from Mississauga and Peel.

**Mr. Conway:** Do you see, from the vantage point of your volunteer group, any diminution in the pressures in that catchment area? Do you see any reason to believe that that facility or some such facility won't be required in the 1980s?

**Mrs. Royce:** No, I fully agree that it will escalate, if anything.

**Mr. Conway:** In your brief on page two, the second paragraph, you indicated that from your association's point of view it would be acceptable, if moneys were required, that certain of the lands at present on the Lakeshore campus be alienated and sold for the purposes of raising certain revenues to reconstruct or to build a new hospital.

**Mrs. Royce:** That was just a practical suggestion.

**Mr. Conway:** Thank you for coming. I certainly enjoyed your brief.

**Mr. Ramsay:** Just on a point of clarification—I apologize for this, I should recognize the problem—the inpatients at Lakeshore are being moved to Queen Street and some are being moved to Hamilton, but these outpatient services that are described in Mrs. Royce's letter, are they being moved as well, or are they remaining at Lakeshore, or is that still in limbo?

**Mrs. Royce:** They're still in limbo.

**Mr. Ramsay:** A decision has not been reached in respect to these things?

**Mrs. Royce:** No. There have been many suggestions about keeping up the continuity, but I really don't see how that can be possible. Since the closure was announced, the whole place has fallen apart as far as staff morale and patient morale are concerned.

**Mr. Ramsay:** Are some of these services that you have described here primarily for the inpatients—in other words they wouldn't be necessary if the patient is moved? I don't mean they wouldn't be necessary, certainly they would be necessary in Queen Street, but they wouldn't be applicable in Lakeshore. Let me rephrase that. The inpatients are being transferred to Queen Street; are some of these services that you describe here for inpatients only?

**Mrs. Royce:** No, they're mostly for outpatients. You can consider the addiction centre people as inpatients, with an outpatient program as well.

**Mr. Ramsay:** Have there been discussions with ministry officials or just with the administration people at Lakeshore as to the possible continuation of these programs?

**Mrs. Royce:** On April 4 we met with Mr. Jappy and the minister and he indicated, we thought, a sort of softening of his attitude towards what we had proposed, keeping some of these on the hospital grounds.

**Mr. Ramsay:** These primarily would be outpatient services?

**Mrs. Royce:** Yes.

**Mr. Lawlor:** Mrs. Royce, I have before me quite a number of documents that have come into my hands from you.

**Mrs. Royce:** We were busy.

**Mr. Lawlor:** First, I am going to ask that the three that are not before you be photostated and distributed to the members of the committee, and I'll leave them with our clerk when we've finished today. The first letter has to do with the February 1—

**Mrs. Royce:** I hope you're not going to zero in on me about those figures now.

**Mr. Lawlor:** Oh, no, I'm on your side, believe it or not. I'm not doing any zeroing here.

**Mrs. Royce:** We're allowed to slant our figures a little bit, the way I understand the slide show was slanted.

**Mr. Lawlor:** In the February 1 letter, which is quite lengthy, first of all you address yourselves to the fire issue, then you describe the lands in the vicinity and point out the cost of locating elsewhere, the capital cost of land if, in the future, it is found it would be necessary to do so, as I believe they will and I think you probably do too. Then you give quite a list of figures, and that's one you don't want me to dwell on to too great an extent, I expect.

The second letter is that of February 26 and I'll pause on that one for a minute. You own—I don't know if "own" is quite the word—you have a building erected out of your own funds and by way of subscriptions and donations from individuals, called Moorhouse. Will you tell the committee a bit about that?

**Mrs. Royce:** It's 11 years old now. We had Mr. Timbrell to our 10th birthday party. The hospital, of course, donated the land to us and we erected the building by beating the bushes for the money, fund-raising

events and subscriptions and donations from the community.

**Mr. Lawlor:** How much did it cost?

**Mrs. Royce:** It cost us—here I go with those figures again—I think around \$40,000, with the furnishing. It could certainly be more than that now.

**Mr. Lawlor:** It's in use at the present time?

**Mrs. Royce:** Yes, it's used seven days a week, afternoon and evening, and approximately 100 patients use it every day.

**Mr. Lawlor:** What do they do there?

**Mrs. Royce:** It's designed as a home away from home, sort of thing, where the volunteers bring the community to the patients and it's as though they were host or hostess in their own home having the patients in. We have coffee and talk over whatever they want to talk about, or play cards and have music, and there's a library. It's just like a small cottage, just like anyone's home.

**Mr. Lawlor:** I take it you can get a bite to eat, can you, a cup of coffee or that type of thing?

**Mrs. Royce:** Yes.

**Mr. Lawlor:** You were highly praised by the minister of the day with respect to the matter.

**Mrs. Royce:** Yes, he is very sympathetic towards it.

**Mr. Lawlor:** Have they given you any assurances, should this hospital be closed, as to what disposition they're going to make of that building?

**Mrs. Royce:** They're very co-operative about that, even to the point of moving it to somewhere we may want.

**Mr. Lawlor:** Any suggestions as to where it might be put?

**Mrs. Royce:** No.

**Mr. Lawlor:** Then you have a letter of March 13 and the final one is April 23. Before moving on to that, on February 26 you were also good enough to write a letter to the local press on this whole issue, isn't that correct?

**Mrs. Royce:** Yes.

**Mr. Lawlor:** Did you get a formal or informal, or any kind of reply—formal, for the moment—from the ministry about this?

**Mrs. Royce:** Which letter are you talking about?

**Mr. Lawlor:** This is the newspaper letter, the open letter that you put in the Advertiser-Guardian. Do you have any reply to that?

**Mrs. Royce:** Not to that one specifically, I don't think.

**Mr. Lawlor:** I only mention it because it's curious. When I was in to see the minister personally quite a while ago now, I presented it to him. He apparently wasn't aware of it and said he took issue with some of your figures and that he was going to reply.

**Mrs. Royce:** I think he spoke to Bud Gregory in Mississauga about it.

**Mr. Lawlor:** I see.

**Mrs. Royce:** He did write a letter to him and I saw a transcript of the letter.

**Mr. Lawlor:** Are you on any of those committees the ministry has set up with respect to outpatient services?

**Mrs. Royce:** I have been included on Dr. Lynes'.

**Mr. Lawlor:** You are on Dr. Lynes'.

**Mrs. Royce:** Yes.

**Mr. Lawlor:** How are you doing?

**Mrs. Royce:** Well, I haven't got a job to lose.

**Mr. Lawlor:** No, no.

**Mrs. Royce:** The very first time I was included shocked me a little bit because this seemed like Utopia. It seemed as if it were a few years from now, and it didn't seem to have anything to do with our patients right at that point and what were we going to do with them, or with the staff and what was going to happen to them. During the one I sat in on the other day, each of them, like Etobicoke and Peel, presented their briefs. I think there is a lot of merit, really, in taking a good look at mental health facilities in our area, but I think to close Lakeshore is not one of the ways, certainly not the way it has been set up anyway of solving the problems.

**Mr. Lawlor:** I would very much love you to expand on that last statement.

**Mrs. Royce:** Well, there obviously hasn't been much planning. You can't just shut the doors or say you are going to shut the doors on a large facility like that and not have the whole place go into shock. It destroys it, I think, right from the start.

**Mr. Lawlor:** Do you understand they are leaving a number of units there?

**Mrs. Royce:** This is the rumour, of course, that some of them will be there.

**Mr. Lawlor:** You spoke of an initial meeting. How many meetings did you have?

**Mrs. Royce:** I have just been out to two with Dr. Lynes, because they broke up into committees. The Etobicoke one met and the



Peel one met, and they may not have been all together again until the other day.

**Mr. Lawlor:** How many meetings were there in Etobicoke?

**Mrs. Royce:** I don't know.

**Mr. Lawlor:** Did you see the number of notices and were unable to attend, or what's the score?

**Mrs. Royce:** No, I wouldn't be included in that.

**Mr. Lawlor:** Oh, were you just asked to drop in to say hello?

**Mrs. Royce:** No, no, not really.

**Mr. Duksza:** You were in the overall committee but not in the subcommittees.

**Mrs. Royce:** Yes, but not in the subcommittees.

**Mr. Lawlor:** Not in the subcommittees.

**Mr. Duksza:** Did you say the overall committee met only twice?

**Mrs. Royce:** As far as I know.

**Mr. Duksza:** I think it's a massive community consultation, post-factum, of course.

**Mr. Lawlor:** You understand they were talking about moving the verbal therapy to Lakeshore Area Multi Service Project Incorporated?

**Mrs. Royce:** Yes.

**Mr. Lawlor:** Have you any thoughts about that at all?

**Mrs. Royce:** No, I don't have the technical knowledge to know whether or not that would be better. I just feel everything is working so well that it does seem a shame to upset it.

**Mr. Lawlor:** Have you any knowledge of what discussions took place with respect to the alcoholic services?

**Mrs. Royce:** As to where they might go, you mean?

**Mr. Lawlor:** Yes.

**Mrs. Royce:** Yes, as Dr. Maharaj said, they were asked to find an appropriate place in the community, but he did have a little difficulty. We have difficulty in Etobicoke getting group homes established, and, as he said, you wouldn't like to live next door to quite a few roaring drunks at some times.

**Mr. Lawlor:** Mrs. Royce, were you involved at the earlier time with respect to the child adolescent care unit and seeking to find accommodation there?

**Mrs. Royce:** No.

**Mr. Lawlor:** I see. What was said to you and what do you understand with respect to behavioural modification?

**Mrs. Royce:** I understood they were looking for an alternative setup, and I think the Etobicoke hospital was one at which they looked.

**Mr. Lawlor:** I personally think they are going to have a hell of a time trying to find alternative accommodation in the Lakeshore area. Have you any thoughts on that?

**Mrs. Royce:** I would agree with you, yes.

**Mr. Lawlor:** In other words, it's a pipe-dream and they are blowing up the flue.

**Mrs. Royce:** To say there'll be no disruption in the continuity of the programs is a great fallacy, I think.

**Mr. Lawlor:** Bear with me for a second, I have to remind myself what you said in that last letter.

**Mr. Duksza:** It is a pity that Mr. Gregory, Mr. Terry Jones and Mr. Leluk are not here to listen to this, since it really directly involves their constituents.

**Mr. Pope:** Oh, come on.

**Mr. Duksza:** I thought I'd get this on the record that they are not here. Are they beyond reason?

**Mr. Lawlor:** I shall see that the members of the committee get your letters. I think they are self-explanatory.

**Mrs. Royce:** Thank you.

**Mr. Chairman:** Mr. Johnston, will you be brief? We are running out of time.

**Mr. R. F. Johnston:** Yes, always, as you have noticed, I am sure.

**Mr. Chairman:** Yes, I know, you are incisive and precise.

**Mr. R. F. Johnston:** Yes, exactly, and I have no supplementaries. You are the only one so far who has mentioned patient morale, which I found interesting.

**Mrs. Royce:** Perhaps we can talk more about it than the staff.

**Mr. R. F. Johnston:** I see, and you also work very closely with patients.

**Mrs. Royce:** I think possibly we have a very close rapport with patients and they will, in some instances, speak more easily to us because we are just people like them, in a way; not staff, that's what I mean.

**Mr. R. F. Johnston:** You only mentioned it in passing, but could you go on about it? What kinds of things are you running into? What kinds of things are coming back to you through your volunteers?

**Mrs. Royce:** They just seem terribly upset and they just don't know what's going to happen to them. There's been the odd incident, as somebody mentioned, of patients



putting their hand through a window in protest and anxiety.

**Mr. R. F. Johnston:** General anxiety and agitation.

**Mrs. Royce:** Yes. For many of them, of course, it has been their home; it's all they have ever known.

**Mr. R. F. Johnston:** I think it's unfortunate in some ways we have to give short shift to the volunteer component in this, having been involved in that side of things myself. I am impressed by the numbers. I know in comparison, say, to Whitby Psychiatric, that is very high. What is it in comparison to Queen Street, as far as numbers of volunteers?

**Mrs. Royce:** We don't have as many, but this is slanted a little bit too in a way, because our volunteers include the different service clubs, like Kiwanis, and this sort of thing.

**Mr. R. F. Johnston:** Are you involved in these outreach outpatient projects as well, or are you just in hospitals?

**Mrs. Royce:** We are into the community with them too. We have some people working with group homes and also in the DARE setup.

**Mr. R. F. Johnston:** Okay, Are any of your volunteers involved in—I forget the name of it—the befriending program in Etobicoke as well; the partners, whatever it's called?

**Mrs. Royce:** I am not sure.

**Mr. R. F. Johnston:** I am just trying to show that one of the ways to actively show how involved the community has been is in the number of volunteers and the way they are integrated. Thank you very much for coming in. I am sorry we don't have more time.

**Mr. Lawlor:** I have one final point. I was looking at this last letter, Mrs. Royce, of April 23, this paragraph, the last from the end: "The conviction that Lakeshore Psychiatric Hospital facilities must be in place and operative before dismantling of any kind takes place has been expressed uniformly by"—and you underline it—"every concerned organization in the catchment area. Surely, therefore, the ministry should feel compelled to deal with the problem accordingly, if it is truly representative and responsible to the community." Thank you.

**Mr. Duszta:** I was going to ask a number of questions on your connection with the other community groups and whether you can give the committee some report of how many people you talk to and the level of upset over the closing of the hospital.

[5:45]

**Mrs. Royce:** I talked to the administrators of the general hospitals in our area and they were all very upset. They have been routinely sending us patients that they haven't the capacity or ability to look after, and especially a crisis patient, and the police bring these types of patients to us too and they are always taken in.

**Mr. Duszta:** How many administrators did you talk to then? Have you actually called all the hospitals?

**Mrs. Royce:** No. Queensway, Mississauga and Etobicoke.

**Mr. Duszta:** Could you tell me a little more about these activities? I think you are a very key person in the sense of being a volunteer and of being part of the community. You must have done a fair amount of calling people to see how upset they were. Most of them cannot be represented here very easily because we have a very tight schedule. I think that is one way of getting some of this down on the multitude of people who are both upset and concerned because what is ultimately the most important thing is concern for the needs of those constituents and the needs of psychiatric patients. Can you tell us, maybe in some detail, how many people you called, whom you called and what kind of response you had?

**Mrs. Royce:** I think that would take a little too much time really.

**Mr. Duszta:** You have a full 10 minutes to make a list, Mrs. Royce. I would love to hear it. It is something that is very essential.

**Mrs. Royce:** You must realize that I am not the only one who has been working on this in our group.

**Mr. Duszta:** Yes, but we have you here. How many of you have been working on this? Maybe that is also an important question.

**Mrs. Royce:** We have 12 or 15 in our executive, and we have all been doing a fair amount of work. Our co-ordinator of volunteers at the hospital, Mrs. Hooton, has been doing a tremendous amount of research on this.

**Mr. Duszta:** Were you involved in the last couple of meetings? One of them was attended by something like 300 people, I know, who protested.

**Mrs. Royce:** At Port Credit.

**Mr. Duszta:** You were involved in that.

**Mrs. Royce:** I was there.

**Mr. Duszta:** Your whole executive in fact has been testing and calling people to get exactly what kind of reaction there is.

**Mrs. Royce:** Yes. We have tried all of the newspapers and the columnists we have known to get this cause before the public because the general public just does not seem to be listening to it for some reason.

I worked in one of the shopping centres collecting signatures. Many people I talked to had no idea other than that Lakeshore is there and has always functioned. They were not in the least bit concerned about what would happen if they had a mental breakdown in that catchment area.

**Mr. Duksza:** They would soon know the problem if it was closed.

**Mrs. Royce:** Unless it was a very quiet one, they would not be able to go anywhere.

**Mr. Duksza:** Have you and your executive called the various social agencies and community groups?

**Mrs. Royce:** I think we have probably touched most of them.

**Mr. Duksza:** Have you talked to an extensive number of organizations and things?

**Mrs. Royce:** Yes.

**Mr. Duksza:** If you were summarizing it from this very extensive contact in the community, is there general upset and concern that the hospital is being closed?

**Mrs. Royce:** The knowledgeable people working in this field would, but as I say, it just does not worry the general public.

**Mr. Duksza:** I think I can understand that at least. First of all, it is the providers of the care who immediately became concerned. Only then does it spread to the people who would be directly involved. Most people say, "Well, no, I am having no troubles." They do not realize that it is always a possibility that it can affect them directly. It is not a box office thing in that sense to save a psychiatric hospital, but it is still essential in some sense to get all those people in. Do you say on the whole that the agencies and the community groups all have expressed almost unanimously some concern?

**Mrs. Royce:** And high praise for the quality of the concern and care that Lakeshore has given.

**Mr. Duksza:** One of the things you said in reply to Mr. Landon was that you think that the services provided have been—

**Mr. Conway:** Mr. Chairman, may I interrupt?

**Mr. Chairman:** We did have another witness scheduled, a Mrs. Best. If the committee wishes Mrs. Best to come back another day, that is up to the committee.

**Mrs. Royce:** I would gladly give up the rest of my time. It is mostly a personal opinion anyway.

**Mr. Chairman:** I don't mean to rush you.

**Mr. Duksza:** Not at all, Mrs. Royce. You represent an enormously important organization.

**Mr. Chairman:** I don't want to do that, Mrs. Royce. At the same time, I wonder what the committee wants because Mrs. Best was here yesterday as well.

**Mrs. Royce:** Let's be fair. I'll give up.

**Mr. Chairman:** I'm just wondering if we couldn't also deal with Mrs. Best tonight before we adjourn.

**Mr. Conway:** I wouldn't want Mrs. Royce to feel cut off.

**Mrs. Royce:** I don't feel cut off. I've got lots to say, but—

**Mr. Conway:** And I certainly wouldn't want the good doctor from Parkdale to feel in any way inhibited.

**Mr. Duksza:** Oh, I'll suffer my upsetness at the moment. I will give in. Anyway, we are within five minutes of closing.

**Mrs. Best:** Mr. Chairman, I wouldn't mind coming back another day.

**Mr. Chairman:** What does the committee wish?

**Mr. Lawlor:** Let's proceed. I think Mrs. Royce has indicated that she is content to allow Mrs. Best to come in.

**Mr. Duksza:** Let's have Mrs. Best in.

**Mr. Chairman:** Thanks very much, Mrs. Royce. I'm sorry for the time squeeze. We appreciate the good work you're doing, and thanks for appearing. By the way, Mrs. Royce, do you wish me to acknowledge your brief in a formal way, or is a verbal acknowledgement sufficient?

**Mrs. Royce:** Yes.

**Mr. Chairman:** Mr. Conway?

**Mr. Conway:** Mrs. Best, what exactly is Community Resources Consultants?

**Mrs. Best:** We are a service for services for therapists in the mental health field. Maybe I could read you a little something that I wrote down.

In 1973 a concern was raised by 40 agencies regarding aftercare for psychiatric patients. The identified areas were a lack of services in housing, social recreational programs, vocational programs and the followup. Also identified was the lack of ability to understand existing services.

Due to the Ministry of Health's commitment to the process of deinstitutionalization,



Community Resources Consultants came into being in the fall of 1974. The objectives, which still stand today, are to provide consultation on existing services for therapists in the mental health field to assist the psychiatric client in terms of the housing programs and the social recreation programs, to identify gaps in the community mental health services and to stimulate change in these fields.

Some of the accomplishments of CRC are the four social therapeutic programs in the areas, two of which are funded at present by the Ministry of Health; two life skills programs and the planning for more; and a proposal for a Parkdale activity centre which is awaiting funding. We have been active in housing, working with the Clarke Institute of Psychiatry to develop a co-operative apartment and with the Queen Street Mental Health Centre to open an 11-bed house in conjunction with their revolving-door program. We assisted in the establishment of Houselink community co-operative homes and a modified boarding home used by Lakeshore and called Regeneration House.

Since 1974 we have seen the development of approximately 100 alternative beds in the boarding home situation, and the Clarke apartment and the Houselink homes have Ministry of Health funding.

We have worked in conjunction with the Canadian Mental Health Association to implement a one-to-one volunteer program for the discharged client; it is called the Rehabilitation Action Program, or RAP.

Specifically, to the closure of Lakeshore: Our board at CRC feels that it does not have access to the facts regarding whether or not the hospital should close and therefore will not support or condone the closure. We do, however, recognize that Lakeshore has a variety of well-respected outpatient services. As a community-based service we feel that comment must be made regarding the process of closure and the time frame thrust on those individuals and services affected by it.

We cannot condone such a major decision being made without any prior consultation with those immediately involved nor an imposed time frame of approximately two months to plan for the alternative service delivery.

The already obvious community needs in Etobicoke, North York, and the city of Toronto will only be exaggerated by the closing.

Community Resources Consultants will continue to function in a consultative function to the mental health professionals.

**Mr. Conway:** Thank you for that. Do I understand this then to be a professional consulting group?

**Mrs. Best:** Yes, funded by the Ministry of Health on an ongoing basis.

**Mr. Conway:** Funded exclusively by the Ministry of Health? I wasn't aware of that.

Your introductory statement certainly covered a range of topics, and I believe you've listened now to two days of testimony. Maybe I'll just ask a final and open-ended question.

You've heard a lot of commentary and testimony here in the last two days. I certainly take from your statement the clear understanding that, as far as you are concerned, there is just no way the community-based mental health services can in any way be expected to continue at the same level with the closure of Lakeshore.

**Mrs. Best:** That would be true.

**Mr. Conway:** No question about that at all. Is there anything that needs to be said that hasn't been said, as far as you are concerned, with respect to this issue?

**Mrs. Best:** Maybe to talk a little bit about the clients. The day after January 23 I drove to the Lakeshore grounds for a meeting. A patient was picketing there and he said they were not asked. I thought that was very relevant. The patients of Lakeshore were not consulted about where they wanted to go for treatment if they required it, and also about where the delivery of their spectrum of services was going to come from. I would assume that Queen Street is a fair distance away from that area, and history has shown that patients in this kind of service congregate in an area very close to where their treatments and services are delivered. At present most of the Lakeshore outpatients do live in Parkdale.

**Mr. Conway:** You would certainly then agree with Mrs. Royce's comment that patient morale and patient concern are at once a high and low level: morale is extremely low and concern is to that degree very high.

**Mrs. Best:** Yes, I would think so. I sometimes have the feeling that people don't think that psychiatric clients ever talk to one another. They know more about what is going on than we would be led to believe.

**Mr. Conway:** What are they saying? Could you take that one step further?

**Mrs. Best:** I haven't talked to that many because I am not in direct service, but the few I do know are concerned. They like the Lakeshore; they like the community that it affords them; they like the staff there. I worked out of Lakeshore in a program four



years ago and I found it a very comfortable place to be. I think this is what they feel too.

**Mr. Conway:** So as that facility exists at present you have no great difficulty with an argument that would suggest it be continued for a number of years.

**Mrs. Best:** Yes, I would say so.

**Mr. Conway:** You are not one of those who believes it is an ancient fire-trap that should be closed in the interests of good, modern psychiatric care.

**Mrs. Best:** I don't know; I don't think the facility really means that much. I think it's the attitude of the staff, and I have always found it extremely comfortable at Lakeshore.

**Mr. Ramsay:** Mrs. Best, just so I can get the Community Resources Consultants clear in my own mind, there are one or two questions in that respect before I come to the other questions.

Are you a Metro-based organization or provincial-based organization?

**Mrs. Best:** Metro, and anybody who needs us, really; we will give them assistance.

**Mr. Ramsay:** Are you and the other people who work with you professional people in the field of—

**Mrs. Best:** Yes, I am a nurse, and there is another nurse and two social workers.

**Mr. Ramsay:** And most of your experience has been in the field of mental health, then?

**Mrs. Best:** Yes.

**Mr. Ramsay:** I was wondering if I could ask you your opinion on whether mental health services are better provided on the premises of a psychiatric hospital such as Lakeshore or in general hospitals or community-based services?

**Mrs. Best:** I have always been of the opinion that I would prefer them to be in a community-based facility. But I think they need a backup, so you are in a bit of a bind because of the different philosophies from a general hospital to a psychiatric facility.

**Mr. Ramsay:** With the closure of Lakeshore, the outpatients there will be treated in community-based rather than in psychiatric-hospital-based premises. I am not trying to put words in your mouth by any stretch of the imagination, but is that not better than perpetuating the stigma that is associated with the psychiatric hospital?

**Mrs. Best:** They go back to an outpatient service which is in a building on the grounds, or they go to a specialized program which

they have off the grounds already, both of which have proved worthwhile.

[6:00]

**Mr. Ramsay:** Should psychiatric hospitals be in the business of providing primary care of the psychiatric patient, and if they are because others don't, shouldn't that situation be changed?

**Mrs. Best:** Are you talking about the acute client?

**Mr. Ramsay:** Yes.

**Mrs. Best:** People like to go back to something they are familiar with, and if they are more chronic types of client and they become acutely ill, they are more comfortable in the facility they have been in before where they got well. I don't think a lot of the people that Lakeshore deals with can be treated in a general hospital because they wouldn't be comfortable in that facility.

**Mr. Ramsay:** I would like to make an observation or direct a question to the chairman. It was suggested here earlier that all members of this committee should visit Lakeshore and should visit Queen Street. I would like to have that opportunity because I feel very much at a disadvantage here in this committee, not knowing the area of Toronto to begin with, not knowing the hospital and its services, not knowing what Queen Street can provide, and not knowing exactly what the ministry is proposing to be done with Lakeshore and with Queen Street. I was wondering whether there would be an opportunity for members of this committee to visit these two facilities and obtain a briefing.

**Mr. Chairman:** If it's the wish of the committee, it is not beyond its scope to take a field trip to both Lakeshore and Queen Street. If the committee wishes to do that, certainly it can be done.

**Mr. Ramsay:** I'd certainly feel much more comfortable.

**Mr. Dukuza:** I like that suggestion, and we must arrange, I think, for something like that. It was already partially discussed by others. I have been there but I'd like to do it again.

I know it may be a bit of an imposition to ask Mrs. Best to come back, but nevertheless I do have a lot of questions. Unless we are going to go on for another hour, I would suggest we do it on Monday.

**Mr. Chairman:** I really don't want to go on. I have a banquet at seven o'clock.

**Mr. Conway:** In Wingham?

**Mr. Chairman:** Not in Wingham, no; in Toronto. We have had a long afternoon and I think perhaps we can call it off.

**Mr. Duksza:** Can Mrs. Best come back? Okay.

When we come back on Monday, can we deal with the field trip too?

**Mr. Chairman:** Can the steering committee deal with that?

**Mr. Duksza:** We have to empower the steering committee to arrange it, to extend it, and to bring us a witness list.

**Mr. Chairman:** Would it be the wish of the committee that Mrs. Best appear first thing Monday?

**Some hon. members:** Yes.

**Mr. Chairman:** Thank you, Mrs. Best.

The committee adjourned at 6:05 p.m.

## SPEAKERS IN THIS ISSUE

---

Belanger, J. A. (Prescott and Russell PC)

Conway, S. (Renfrew North L)

Duksza, J. (Parkdale NDP)

Gaunt, M.; Chairman (Huron-Bruce L)

Johnston, R. F. (Scarborough West NDP)

Lawlor, P. D. (Lakeshore NDP)

McClellan, R. (Bellwoods NDP)

Pope, A. (Cochrane South PC)

Ramsay, R. H. (Sault Ste. Marie PC)

**From Lakeshore Psychiatric Hospital:**

Bond, Dr. I., Medical Director

Barnes, E., Chief Engineer

Frank, Dr. F., Special Observation Unit

Maharaj, Dr. N., Director, Alcohol Services Unit

Suttis, T., Head, Maintenance Department

**From the Ministry of Health:**

Surplis, Dr. D. W., Special Assistant to the Minister

**From Hamilton Psychiatric Hospital:**

Morin, F. F., Administrator

**From Queen Street Mental Health Centre:**

Anderson, Dr. D., Director

Fisher, M., Administrator

**Witnesses:**

Best, Mrs. J., Housing Consultant, Community Resources Consultants

Royce, Mrs. C., President, Lakeshore Volunteers Association





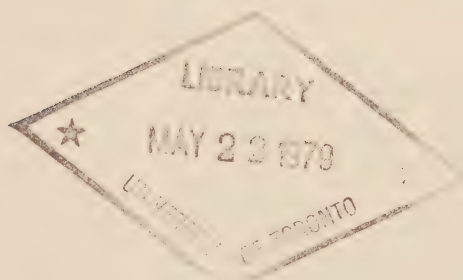
No. S-8

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Monday, April 30, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

MONDAY, APRIL 30, 1979

The committee met at 3:25 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Chairman:** We have before us Mrs. Best. Would you kindly come up again?

**Mr. McClellan:** I wonder, Mr. Chairman, before we start hearing evidence, could we have an update from the ministry about the financial data we had requested regarding the province's calculations of the amount of the federal health transfers and the formula and criterion used for calculating those figures?

**Mr. Chairman:** You are on with Mrs. Best.

**Mr. Duksza:** Oh of course, yes.

**Mr. Chairman:** Is there anyone here from the ministry who could assist in that respect?

**Dr. Surplis:** The request was made to the Treasury, which is the responsible ministry for those figures.

**Mr. Chairman:** Is there anyone here from Treasury who could assist?

Well, we'll have to try to contact someone in Treasury then, or—

**Mr. McClellan:** May I ask you, Mr. Chairman, if you would make some inquiries as to whether the committee will be given that information while we are still sitting?

**Mr. Chairman:** Right. Perhaps, and I am just thinking out loud here, it would be convenient tomorrow for someone from Treasury to come for a few moments. I don't anticipate it would take very long.

**Mr. McClellan:** No, I would think that somebody could explain it to us in five minutes or even give us a two-page piece of paper that would indicate the amounts and the formula. I don't see it as a major difficulty.

**Mr. Chairman:** Perhaps we could arrange to do that tomorrow. Do you wish the chair to do that, Dr. Surplis, or would you undertake to do that?

**Dr. Surplis:** I'll go and look right now.

**Mr. Chairman:** Thank you.

When we adjourned, Mr. Duksza had the floor.

**Mr. Duksza:** Mrs. Best, where do you get your money from? Who pays for your programs?

**Mrs. Best:** The Ministry of Health.

**Mr. Duksza:** The Ministry of Health. Which branch?

**Mrs. Best:** The Adult Community Mental Health Branch.

**Mr. Duksza:** Could you tell us about the problems that you handle? I mean, how many homes do you supervise; how does it work?

**Mrs. Best:** We are a service-to-service; a therapist from a hospital would call our service and ask for some help. I can give you an example. A lady, say, has been hospitalized and is now ready to leave but needs housing; she possibly needs a social recreational program. We would make a couple of recommendations in the housing area and maybe a couple of recommendations in social recreational programs, possibly a vocational program to upgrade her skills—  
[3:30]

**Mr. Duksza:** Go on.

**Mrs. Best:** The therapist would then take these back to the client. Housing could be a co-operative, a boarding home, or a place like the Y's Woodlawn. A social recreation program could be a day program like, say, the Keele Women's Group up in York, or an evening social recreation program like the Bloor-Spadina Club. A vocational program could be the George Brown rehabilitation through education program or the For You program.

**Mr. Duksza:** Yes. How many people work with you?

**Mrs. Best:** There are five consultants, a director and a secretary.

**Mr. Duksza:** How many clients use your services?

**Mrs. Best:** I couldn't give you that statistic but I could get it for you. We service any psychiatric facility in the general hospitals, the Clarke Institute, Lakeshore—



Mr. Duksza: Oh, you do quite—

Mrs. Best: Oh, yes, we give service to any Metro psychiatric facility, plus anybody outside who requests assistance within the Metro area.

Mr. Duksza: A number of people obviously go to their own apartments, homes, their own families, et cetera, but there must be a significant percentage from all the units, but specifically from Lakeshore and from Queen Street, who have no place to go. That's the number I am interested in, first. Second, what will happen to them ultimately if they have no place like Lakeshore to go? Could you tell me how many of those people who have no place to go and for whom you really have to work in finding a place are involved?

Mrs. Best: I am the housing consultant and between the two psychiatric facilities, Lakeshore and Queen Street, we have a number of recommended homes; there are 28 all told as of yesterday. That changes very rapidly, and we look at about 520 beds in that area.

Mr. Duksza: Where are they situated mostly?

Mrs. Best: Mostly Parkdale.

Mr. Duksza: From Roncesvalles all the way to Dovercourt approximately?

Mrs. Best: Yes.

Mr. Duksza: You must be aware, of course, of the recent problems in the area. There was a meeting last week and two aldermen have been involved on the task force on the bachelorettes. There is a group which is now reacting one way or another to the group homes. Does that changed political situation give you some concern, Mrs. Best?

Mrs. Best: Yes, it does, because there has also been a ruling by the OMB that there would be no more lodging group homes set up south of Queen Street to the bay. The Toronto city group home bylaw, called residential care facilities, is excellent and it has opened the avenue for us to move out, but at the moment, we don't have any group homes for psychiatric clients. We have alternatives, but they are modified co-operatives or co-operative living arrangements in which we can place clients other than the boarding home arrangement.

Mr. Duksza: Would it be correct to say your facilities are as full as possible and the pressure will grow and not lessen in time?

Mrs. Best: I would say so, yes.

Mr. Duksza: We'll return to what was going on in ward two because that's ward two we are talking about more than a provincial riding. Ward two is composed of three

half-ridings, the lower half of those three ridings. There is a movement, of course, to limit and diminish the number of group homes. It's a community-wide pressure now which is expressed partially by two aldermen. That would mean, I would say, just looking at it, that there would be even less opportunity. You are aware of that, of course.

Mrs. Best: Yes.

Mr. Duksza: Yes. If the hospital remains closed, as it's proposed to, do you think in your opinion there would be any added or extended pressure put on your resources by closing of the hospital?

Mrs. Best: Oh, definitely.

Mr. Duksza: Do you have a sort of idea of how much pressure there would be? Have you sort of been calculating, because I know you are in opposition to do that? You must have been thinking extensively about what it would mean in terms of pressure on already limited resources in your department.

Mrs. Best: Yes, this is true, because we have programs that aren't funded. So they're limited to the amount of people who can be sent to them. The ministry set up Dr. Lynes' committee, the implementation committee, to look at these problems that are going to occur. One thing that seemed to come out of that, that was clear to me, was that we didn't have good statistics on what would happen to the surrounding communities if Lakeshore closed. There seemed to be a great deal of error in that area of a statistical package.

Mr. Duksza: I think you mean there are none at all, because no preparation was done, to start with. No wonder there are no statistics.

Have you been dealing with the ministry in terms of getting money and permission for more group homes in other areas besides Parkdale? Have you been dealing with the ministry saying, "We need more group homes"?

Mrs. Best: Not really, no.

Mr. Duksza: Is it something that you discussed with your own people in terms of need for that?

Mrs. Best: Yes.

Mr. Duksza: What would be your estimated need on that?

Mrs. Best: It's really difficult to say. Those are boarding homes, which have no therapeutic content. We're looking at homes that have a therapeutic content, although the Ministry of Health did, just recently, fund house-link community homes. They didn't

fund the homes; they funded the programs to go into the homes. Both the ministries of Community and Social Services and Health, have stopped funding homes, but they will fund programs to go into the homes. So you have to set the home up, and then apply for the funding.

**Mr. Dukszta:** You are so directly involved in it—you must be. I worked, as you know, in Queen Street when we began discharging people into the community. What appears now, after many years of development, is that from many of the group homes, boarding homes, many of the patients have simply been transferred out—out of sight, out of mind, so to speak—into the community without real programs of rehabilitation or retraining being available to them; in effect, transferring them backward into the community. Is that your impression too?

**Mrs. Best:** Partially.

**Mr. Dukszta:** Partially. Have you been very concerned? Have you had some thoughts on how to change this and have you had any success in persuading the authorities?

**Mrs. Best:** I would say the social therapeutic clubs that CRC funds would take up some of the slack in this area, and the housing they have been involved with, which is very limited-cost housing. It doesn't cost very much at all to set up the co-operative alternative housing.

**Mr. Dukszta:** From what you know of the people of the community, are they concerned about the closing and what it will do in terms of the long-term population?

**Mrs. Best:** Very much so.

**Mr. Dukszta:** Who have you been talking to?

**Mrs. Best:** The community at large. People from Lakeshore, people from Queen Street, people from the other boroughs.

**Mr. Kennedy:** Just one question. You mentioned the closing of Lakeshore would add additional pressure to the work you're doing, I presume because the patients would come in to the Queen Street hospital. Would this be because of the closing of the Lakeshore? Regardless of that, Queen Street has a certain capacity for patients. Would you agree that as Queen Street builds up, it would reflect on the work you do and increase the load?

**Mrs. Best:** I think it would increase the load because there will be more people just in that area. Some of the services that Lakeshore provides won't be as close to the client who is going to be in the hospital.

**Mr. Kennedy:** Would the clients be different? For instance, if there are 100 beds to be filled at Queen Street, presumably with one or several categories of patients, the work you do would increase just because of this increase in the numbers in the hospitals, regardless of, say, the source of these 100 patients. Is that correct? Do you follow what I mean?

**Mrs. Best:** No, I'm afraid I don't. There will be an increase in our caseload because the suggestion of the closure of Lakeshore is that the client is now going to be treated in the community; in Queen Street and then in the community.

**Mr. Kennedy:** We're speaking of inpatients?

**Mrs. Best:** You're speaking of inpatients.

**Mr. Kennedy:** Yes. So, regardless of where they come from, if there's room at Queen Street, your community work would increase?

**Mrs. Best:** Yes.

**Mr. R. F. Johnston:** I would just like to pursue a little bit the matter of concern by other community groups. In looking at the transcripts lately, I've seen that certain of us, myself included, have been guilty of leading witnesses and putting out major statements. Then we get a "yes" or "no" answer, instead of getting it in the witnesses' words. You said to Dr. Dukszta that you had heard concern expressed by various people in the community. I wonder if you could give me some examples of the ways in which people phrase their concerns? I would like to break it down into two groups: (1) community people you have been talking to, and (2) professionals from the various agencies and hospitals that you deal with.

**Mrs. Best:** I think they are just generally concerned about what's going to happen to their services. They all express the feeling that they really don't know what is going to happen when it closes, that they will meet the needs initially. But what's going to happen some way down the road? I think some of the professionals feel the client should be treated in his or her own community and you would have to have a place from which to treat them.

**Mr. R. F. Johnston:** So that would be referring specifically to having a Lakeshore that would—

**Mrs. Best:** Yes.

**Mr. R. F. Johnston:** You have been involved with the Lynes committee dealings, I gather. How many meetings of that committee have you been to?



Mrs. Best: Two.

Mr. R. F. Johnston: Have there been others that have gone on and you weren't able to attend or you weren't invited?

Mrs. Best: I wasn't invited.

Mr. R. F. Johnston: This is the committee that's supposedly coming up with the answers to make sure that nobody is hurt by this move. From the two meetings you attended, what was your feeling? Did you feel they had come to grips with this?

Mrs. Best: I think they're doing an admirable job, but the time frame has been sheer hell. You just can't do this kind of community planning in two months. In fact, they did change the date originally, I believe, from March 20 to April 20. I think the communities themselves rose well to the task. I've been very impressed with the "packages" that have come in, but already they're using a pre-existing package that was asked for last June by Canadian Mental Health Services and the ones that didn't get funded are being brought forward again, plus new ones.

Mr. R. F. Johnston: I see. So your interpretation is that groups that applied for funding last year to do community work but did not receive it are now the ones receiving the bulk of this money coming from this ministry?

Mrs. Best: They're being looked at.

Mr. R. F. Johnston: Looked at?

Mrs. Best: Yes.

Mr. R. F. Johnston: Therefore, those groups, when they applied obviously thought they would be funding existing needs prior to, and not looking at, these extra needs that will be coming up because of Lakeshore?

Mrs. Best: That's right.

Mr. R. F. Johnston: Okay. There, I led you instead of letting you say it yourself. That's all I have to ask.

Mrs. Campbell: I wonder if I might ask you a question. I have been in touch with the minister and I have a letter from him dated March 30 in which he says:

"The present outreach services administered by Lakeshore Psychiatric Hospital will be taken over by Queen Street Mental Health Centre, but we do not anticipate relocating them closer to Queen Street Mental Health Centre. We envisage them forming satellite operations at or near their present location. In addition, we have been soliciting the opinions of many agencies with regard to additional outreach programs required in that particular area."

[3:45]

He states that he's not in a position at this time to give specifics as to these additional programs but hopes to finalize the proposals by late April or early May.

I am sorry I came late and may have missed some of what you've said; my apology. What definite discussions have there been, and have you any idea now as to what these additional programs are that the minister is referring to?

Mrs. Best: This would be the package from last June.

Mrs. Campbell: But they haven't been finalized as yet, so it's still up in the air and no real proposal?

Mrs. Best: It's kind of sitting on the edge. They have talked about it, but the actual cash dollar that they would give to each program has to be checked out yet.

Mrs. Campbell: So as we're into early May almost, we're still all up in the air. When I had occasion to be out in Peel a month or so ago—perhaps longer than that—I was advised that in that area there aren't programs in place such as contemplated by the minister here. Can you comment on that at all?

Mrs. Best: I believe they have one after-care program and they have proposals in for five more, with a dollar value on their proposals.

Mrs. Campbell: So that again these things have not been in place but they are sort of scurrying to try to meet the objectives of the ministry as a result of the proposed closing?

Mrs. Best: I would say so, yes.

Mr. Turner: Mrs. Best, with the closing of the Lakeshore Psychiatric Hospital, outpatients are going to be treated in a community based centre or resource centre, if you will. Would you not agree that that would be a better way of treating these patients, rather than having them in a psychiatric hospital facility?

Mrs. Best: Oh yes, but they're already being treated out there.

Mr. Turner: To some degree.

Mrs. Best: Yes.

Mr. Turner: On Wednesday, you indicated that you agreed with Mr. Conway's statement, and I quote: "There is no way that the community based mental health services can be expected to continue with the closure of Lakeshore at the same level." The ministry, on the other hand, I'm told has pledged to retain all existing outpatient programs at Lakeshore to ensure continuity of care and has pledged to enrich the community-based services by \$1.3 million. Given that commitment, could you tell me why you feel the



community-based services won't continue at that same level or at the present level?

**Mrs. Best:** I believe they will attain a level, but I don't think that anybody could tell you what level they are going to come to. If you're treated in Queen Street and you're going to live in Parkdale and the outpatient facility is in Etobicoke, I don't know, it just doesn't seem right to me. That's a personal opinion, it's not my board's opinion, but I would say that if you are treated in that manner, which is the route that it's going to be treated in the future, it would be difficult, although Lakeshore has the finest outpatient facilities and I would certainly hope they're all refunded and they all stay in the Lakeshore area, because they are very valuable.

**Mr. Turner:** I think the ministry has indicated that.

**Mrs. Best:** Yes, all existing services, that's right, but they're having some problems.

**Mr. Turner:** So in actual fact what you're indicating is a personal opinion rather than factual evidence?

**Mrs. Best:** I don't think there are any statistics on it.

**Mr. Dukszta:** Did you say it was unfactual, what you were saying, Mrs. Best?

**Mrs. Best:** There are no statistics on it.

**Mr. Turner:** I asked her that.

**Mr. Dukszta:** That doesn't mean it's unfactual.

**Mr. Sweeney:** Who is the witness, Mr. Chairman?

**Mr. Turner:** However, I don't want to get into a debate. Thank you very much. One other question if I may, Mr. Chairman. I would like to know if your organization has been involved in the meetings the ministry has chaired with community groups to discuss expanded community-based services for programs in the affected area?

**Mrs. Best:** I have been to, I would say, all but maybe five, in all the boroughs.

**Mr. Turner:** So then you are being a part of the process of discussing the future of expanded programs?

**Mrs. Best:** Yes, I'm a community-based program. I do believe in community.

**Mr. Turner:** Right, good. Thank you, Mr. Chairman.

**Mr. Chairman:** Thank you very much, Mrs. Best.

**Mr. Sweeney:** I have a couple of questions for clarification, Mrs. Best. Did I understand you to say you had the sense that people who are being treated at Queen Street and living at Parkdale would have to attend an

outpatient centre in Etobicoke? Is that what you said? Could you explain that to me? I don't quite understand that flow.

**Mrs. Best:** That would go back to one of the points that Dr. Dukszta made. If somebody hasn't a family or a place to return to there is very limited housing resources in Etobicoke, so they would probably end up living in Parkdale.

**Mr. Turner:** Is that not, though, a hypothetical type of point?

**Mrs. Best:** There are only two boarding homes in the Etobicoke area and they're on the Lakeshore. There are a few homes for special care—

**Mr. Sweeney:** As far as you understand it, where do the people who are at present being treated at Lakeshore in the outpatient service live if they're from the general Etobicoke area now?

**Mrs. Best:** They live in Parkdale. They have a reason to go back for their hospital-based program.

**Mr. Sweeney:** But if they're being treated as outpatients in Lakeshore, they would live in Parkdale?

**Mrs. Best:** If they had no home in Etobicoke, yes.

**Mr. Sweeney:** I guess that's where I'm losing track. I don't see the difference between what's happening now and what you describe is going to happen. I'm missing something, very obviously, because it's going to continue to be outpatient in the general area where Lakeshore hospital is now. Right?

**Mrs. Best:** That's right.

**Mr. Sweeney:** The people who are at present being treated there now, you suggest, live in Parkdale, so what's going to change?

**Mrs. Best:** I don't know, and I say you can't prove it.

**Mr. Turner:** That's right.

**Mr. Sweeney:** Well, I'm not—excuse me—I'm not suggesting that you need to prove it. I'm just saying what do you think is even going to change? What do you perceive might change?

**Mrs. Best:** I have no idea.

**Mr. Sweeney:** So it's this uncertainty that concerns you, as opposed to any clear knowledge that something's going to happen?

**Mrs. Best:** That's right.

**Mr. Sweeney:** Okay.

**Mr. Chairman:** Thanks very much, Mrs. Best. I appreciate your attendance. Mr. Fisher, the administrator of Queen Street Mental Health Centre. We're not quite on

schedule, sir. We indicated 3:30, but we're moving along, Mr. Conway.

**Mr. Conway:** Thank you very much, Mr. Chairman. Recognizing that there are a number of members who I'm sure will want to deal with this witness, I'll confine my remarks to a few questions.

**Mr. Fisher:** you are the administrator of the Queen Street Mental Health Centre?

**Mr. Fisher:** Yes.

**Mr. Conway:** How long have you occupied that position?

**Mr. Fisher:** Since June 1976.

**Mr. Conway:** Prior to that position, you were where?

**Mr. Fisher:** I was administrator at Whitby Psychiatric Hospital.

**Mr. Conway:** For how long were you at Whitby?

**Mr. Fisher:** September 1971 until June 1976.

**Mr. Conway:** So you have been an administrator of two of the largest provincial psychiatric institutions in the past eight years?

**Mr. Fisher:** Yes, that's fair.

**Mr. Conway:** Could you indicate to us whether or not you were in any way consulted prior to January 22 about the recommendation that the minister announced on that day, involving the closure of Lakeshore and the transfer of much of its catchment area and patient load to your facility?

**Mr. Fisher:** I was not.

**Mr. Conway:** You were in no way consulted? Can you indicate very briefly the kind of relationship your facility had with the McKinsey group as it prepared its report and recommendations?

**Mr. Fisher:** The McKinsey group sent consultants to Queen Street Mental Health Centre and these consultants interviewed the staff at Queen Street Mental Health Centre at length through a period from about June through August, I think, of 1977, and they were there intermittently during this period. They were also visiting Whitby and Lakeshore at that time.

**Mr. Conway:** Did you in your facility have any kind of organized interface, for lack of a better word, with the McKinsey group? I believe it was the people from Lakeshore who indicated they had a special committee that dealt with the McKinsey group. Was there any such organized group at Queen Street making recommendations or discussing the matters on an ongoing basis with the McKinsey group?

**Mr. Fisher:** I don't recollect an organized group. I think we more or less arranged for them to meet with various groups.

**Mr. Conway:** Were you in any way surprised at the report of the McKinsey group, and could you indicate—perhaps rephrasing the question—your view as administrator of the Queen Street Mental Health Centre of the main recommendations of the McKinsey report?

**Mr. Fisher:** I really wasn't surprised, because I had been apprised of the report while it was being developed. As far as the main recommendations are concerned, I approved of that part of the report which stated that better use should be made of Queen Street Mental Health Centre beds.

**Mr. Conway:** In that connection, and reserving the discussion on the McKinsey report as it related to the rebuilding of Whitby and Lakeshore, can you give this committee some historical information about the opening of the new facility and, in particular, the development of the beds at that facility since much has been said by the minister and others in the recent past that the reason the government can ignore the recommendation to rebuild Lakeshore is that there is such significant unused bed capacity at present extant at Queen Street. Can you indicate just how that came to pass, how it was that so much unused capacity was developed at the new Queen Street Mental Health Centre, and was it always so?

**Mr. Fisher:** I could try, Mr. Chairman, may I refer to my notes?

**Mr. Chairman:** Indeed.

**Mr. Fisher:** The original plan for building of Queen Street Mental Health Centre intended that there would be 700 beds, and in, I think it was about July 1977, the Metfors organization was formed, and two floors of 34 beds were taken for the Metfors organization.

**Mr. Conway:** For the benefit of the committee and those who may not be aware, could you just indicate briefly what Metfors is?

**Mr. Fisher:** Metfors means Metropolitan Toronto Forensic Service. It's operated under the auspices of a private board. It's financed through the office of the Attorney General (Mr. McMurtry), I believe, and was developed to serve the courts in Metropolitan Toronto.

**Mr. Conway:** All right. Go ahead.

**Mr. Fisher:** That left 632 beds, and in anticipation of this question I did a study of our relative census and beds available on



April 23, 1979, and I could give you the summary of this. On that day we had a total of, as I said, 632 beds available and we had a total of 458 beds set up. That left 174 beds not set up but available.

**Mr. Conway:** As to those beds that were available and not set up, can you just clarify for me what it is you mean by that in an administrative sense? Were those beds that were, in physical plant terms, there and all they needed were patients to fill them?

**Mr. Fisher:** We had them in storage. Yes, they're available, but for example on our unit two we have a completely vacant ward of 34 beds. On unit four there's another completely vacant ward of 34 beds. Actually there's another ward on unit two of 14 beds completely vacant and another ward of 14 beds vacant on unit three. There are some un-utilized beds on some of the other wards that are not set up.

[4:00]

**Mr. Conway:** What is that total again?

**Mr. Fisher:** The difference between the intended bed capacity and the actual beds set up on that ward would be those wards which are entirely vacant plus those wards in which fewer beds are set up than was originally intended.

**Mr. Conway:** That totals about 160.

**Mr. Fisher:** One hundred and seventy-four as of April 23, 1979.

**Mr. Conway:** Just to go back for a moment. In your time at Queen Street, the new centre, have most of those 174 beds been unused capacity since the facility opened?

**Mr. Fisher:** Yes, that's true.

**Mr. Conway:** Prior to January 22, 1979, what was the intended use of that unused capacity? Were there any plans for those unopened wards?

**Mr. Fisher:** Actually, it hasn't been unused in that sense. I think one or two of the wards have been unused, but some of the wards intended for beds have been used for day-care programs.

**Mr. Conway:** When was that facility opened?

**Mr. Fisher:** Queen Street? The final building plan was completed in August 1978 and it was built between 1971 and 1978.

**Mr. Conway:** Prior to January 22, 1979, there was, in so far as the bed rating at Queen Street is concerned, unused capacity, notwithstanding the fact certain of those ward areas were contemplated and were in fact used for such purposes as you just indicated. What I'm anxious to know from the

point of view of long-term planning is what were the plans with such a new facility when you arrived there in 1976 and throughout the period of two and a half to three years? Was it intended that those ward areas we're now expected to fill with active beds, in the sense that we know them in a psychiatric institution, should be anything more than reserve capacity for such uses as day care?

**Mr. Fisher:** I think the original intention was to build an institution that would have been needed in the Metro area, but as you may know, the planning for a facility requires considerable lead time, and during that period the population in psychiatric hospitals dropped dramatically. At one time I think Queen Street had over 1,200 patients.

**Mr. Conway:** Could you indicate to me and to the members of the committee how much of that 174-bed excess capacity, in terms of just general space allocation, was utilized for such purposes as you've indicated with day-care facilities?

**Mr. Fisher:** To some extent, most of it was.

**Mr. Conway:** What, pray tell, is going to happen to those facilities now if the minister has his way and that area is used entirely for the purpose of bedding patients?

**Mr. Fisher:** We'll use other space we could have been using for day-care facilities. The building was planned for 700 beds on each floor. You'll have to visualize the way the buildings are constructed. There are four towers and there are five floors in each of the towers. Each of these floors is served by three or four conference rooms which can be used for group therapy. There are two day rooms in each of the wings where patients are housed on most of the floors. In two of the towers, there are finished basements with daylight. The basement wall extends so there are slanting windows which provide daylight into the basement rooms. There are seven or eight conference rooms or classrooms in the basement. They are very fine rooms, well lighted and very pleasant.

**Mr. Conway:** Are they finished?

**Mr. Fisher:** They are finished on two of the units and on two of the units we are planning to add seven more rooms each, which will get us quite a large amount of capacity for day-care activity.

**Mr. Conway:** In terms of the basement capacity, then, we're talking about using space that heretofore has been basically left in abeyance?

**Mr. Fisher:** It's been used from time to time, but under-utilized.



**Mr. Conway:** You see, I have this impression, Mr. Fisher, of an additional, 200-odd patients going into this facility, pushing day-care facilities out of the unused wards—unused in the sense of their original intention. Then I visualize those facilities being backed up into basements and that space, which was presumably used for other purposes, being backed out on to Queen Street itself. So there is that much capacity at Queen Street?

**Mr. Fisher:** There is quite a lot of capacity at Queen Street. You'd have to see it.

**Mr. Conway:** Unfortunately I'll be seeing it tomorrow and I regret that I haven't been able to get out before now. How do you feel about the ability of your centre to deal with the patient load to be directed its way, given the minister's announcement of January 22?

**Mr. Fisher:** You have to understand that it isn't just the present centre. As the patient load is shifted from Lakeshore, most of the clinical staff, or a very large part of the clinical staff, will shift with that patient load, so that from the standpoint of ratios of staff to patients, there will be no reduction in that ratio. I'd say we would be able to cope very well.

**Mr. Conway:** Dr. Bond, the medical director at Lakeshore, indicated that one thing that makes that hospital different from other mental health centres is that it has a very high admission rate. It is, in a sense, a very busy hospital and has been much busier than facilities such as your own. Does that kind of consideration concern you about your capacity?

**Mr. Fisher:** Oh, I really wouldn't want to quarrel with Dr. Bond's statistics but I'd say that probably Lakeshore and Queen Street are the two busiest hospitals, yes. I think they are fairly comparable in number of admissions.

**Mr. Conway:** How do you feel about the catchment area that you are going to develop, since it is going to involve a huge slab of one of the fastest-growing parts of this province and, indeed, the country, and for which the projections are quite serious, notwithstanding what we've known to be the case with admissions in the recent past? Does that present you with a concern?

**Mr. Fisher:** That's a complex question you are asking. Yes, I'd say there is a concern there but I'd have to elaborate in order to explain what that concern is.

**Mr. Conway:** Please do.

**Mr. Fisher:** It's predicted that the area will be fast-growing and, if it does grow that fast, will require more co-ordinated mental

health planning and programming in the Metro area. In my view, this is a good thing.

**Mr. Conway:** We have been led to believe by some very experienced and dedicated professional and volunteer witnesses in the recent past that the bureaucrats may indeed be able to reassign the catchment areas, but that in terms of community-based mental health services, that transfer is going to be much more difficult. Indeed, one witness indicated last week that from her point of view it was very unlikely that that transfer could be effected from the west end of the city of Toronto to the area of Queen Street with very much success. How do you respond to that?

**Mr. Fisher:** I can't comment. As you know, a committee was appointed under Dr. Pat Lynes to study the needs for after-care and day care in the Lakeshore catchment area. I am not a member of that committee. I can tell you what Queen Street has done in response to that anticipated problem. We have established a Queen Street outpatient planning committee and we have done everything we could to anticipate the problems. We have met with staff from Lakeshore and we are now waiting for Dr. Lynes' report. We feel we are about as well prepared as we can be, under the circumstances, to deal with that report.

**Mr. Conway:** That's an important point. You mention you are as well prepared as you feel you can be, under the circumstances. It seems to me that the circumstances in this instance are alarming, to say the least, because you have been given roughly three months, as of this date, to prepare yourself for the transfer of a catchment area that has had a facility for almost 90 years. During that time, according to many credible witnesses, there have developed some of the finest community support services available anywhere in the country.

You have three months, and now probably till September 1, another four or five months, to prepare a community which—if one is to believe what we are told by people such as certain aldermen in the city of Toronto and very concerned people in south Parkdale—feels that Queen Street is already perhaps taxing the capacity of that community, which the good doctor knows far better than I, to deal with what it has at present, to say nothing about what will be the case a year from now if this transfer is effected.

How do you feel about the support services and the capacity of south Parkdale to handle, given present problems, the full

impact of this transfer which will make yours a very heavily utilized facility?

**Mr. Fisher:** My support services, or do you mean the hospital support services?

**Mr. Conway:** And the community support services—housing and such-like.

**Mr. Fisher:** To answer the first question, our plans are in place within Queen Street. We have been meeting very frequently and we have plans in place to handle the transfer. As far as Parkdale is concerned, it's my impression that many of Lakeshore's after-care patients at present reside in Parkdale, and I don't think it will make any difference at all.

**Mr. Conway:** So to that degree you would dispute the claim of those in south Parkdale who draw attention to the fact that the community is at present overburdened with these and other problems?

**Mr. Fisher:** In the short run, if many of these after-care patients are living in Parkdale, I can't see what difference it will make if there is a change in jurisdiction or hospital. If you look at it in the long run, unless other resources were to have been found by Lakeshore, other than Parkdale, what difference would it make?

**Mr. Conway:** But surely it makes a difference if your bed capacity increases by 30 to 40 per cent; that's not an unlikely conclusion, is it, to suggest that that alone will create far greater pressures on the community?

**Mr. Fisher:** That may create some pressures, yes. As I suggested earlier, I think we are faced with a need for more co-ordinated mental health planning in Metro, which I said before I think is a good thing. The example I could give you from the McKinsey report is that Scarborough General and Scarborough Centenary hospitals have been operating a co-ordinated mental-health-care plan for several years now and the proportion of admissions to Whitby Psychiatric Hospital from Scarborough was far lower than you would expect.

If you were to take a look at the entire catchment area for Hamilton Psychiatric Hospital, for example, there are about 1,800,000 people in the catchment area. I am not absolutely certain of the numbers, but I think Hamilton admits around 900 patients a year. That's 30 per cent fewer than Whitby, with a similar-sized catchment area. This I have to attribute to system design for mental health care. I think it makes sense to look at systems and I think patients could be better served if the systems are well designed.

**Mr. Conway:** In terms of systems and systems design, I would probably agree in part, although I am always confused by the bureaucratic overtones of those kinds of phraseologies. But surely these are the sorts of things that an experienced and internationally renowned group such as McKinsey would be both aware of and, having had time to study the matter, would surely have taken into consideration.

I want to get a clear answer from you because I think I strayed away from this earlier. In terms of the long-term future, and quite apart from budgetary considerations which, if one is to take the minister's statement of January 22, were not altogether apart from this decision, how do you feel about the long-term planning as it relates to the McKinsey recommendation which calls for the reconstruction or renovation and obviously the keeping in place of both Whitby and Lakeshore? How do you feel about that recommendation which directs the government of Ontario to rebuild or substantially renovate and keep in place the Lakeshore Psychiatric facility?

[4:15]

**Mr. Fisher:** The question of systems design was explicitly excluded from the terms of reference of the McKinsey committee. They were not to look at the system—that is the overall system. As you well know, mental health care is not confined to the psychiatric hospitals, nor psychiatric hospitals plus general-hospital, psychiatric units. It involves all of the agencies, all of the health professionals in the area who are responsible for mental health care.

So, in the summary report, as you may have seen, the McKinsey people alluded several times to the fact that if the system were changed, and they specifically referred to Scarborough, either it could have an impact on their figures either positively or negatively. So they were taking off on the 1977 base, in effect, freezing that base and projecting it into the future. I think they did a tremendous job.

**Mr. Conway:** But you're almost suggesting, indeed for me you are suggesting that the government, inadvertently or otherwise, loaded the gun against itself with respect to getting a recommendation which clearly its budgetary capacity now cannot handle. I'm gleaning that from what you say.

**Mr. Fisher:** I have no such intentions there.

**Mr. Conway:** I think I represent your case fairly when I suggest that from what you've indicated to us you're suggesting that perhaps by taking a full systems approach to



mental health services in Metropolitan Toronto there is a good case to be made for phasing out such facilities as Lakeshore so long as that whole integrated approach is dealt with.

**Mr. Fisher:** I think there is a good case to be found, if you study the McKinsey report, in using the figures in the study that they have completed. In their comparison, they dealt with options and one of the options was to phase out both Whitby and Lakeshore and require the psychiatric units of general hospitals to take up the slack. They pointed out many good reasons why this could not be done. They had a rating scale in which they gave weight to these various components of the alternatives, but what they didn't consider was the possibility of using what they considered to be difficult beds at Queen Street as an option. It seems to me that that option, which is one I must guess the ministry has taken, has much to recommend it.

**Mr. Conway:** Increasingly, general hospitals have played an important role in the delivery of institutional psychiatric services, is that correct?

**Mr. Fisher:** Yes, that's true.

**Mr. Conway:** Would you not agree that with the severe budgetary restraints that are being placed, generally speaking, among the public hospital sector, it is going to become more and more difficult for general hospitals to play their traditional role in the provision of institutional psychiatric services?

**Mr. Fisher:** I really can't comment on that, sir. I'm not that cognizant of our general hospital problems. I do know that in the Scarborough area the manner in which the resources are used contributed as much to the kind of system they developed there as the numbers of staff they had. I think we ought to take a hard look at the Scarborough-Hamilton systems. It may well not be as expensive as one would anticipate.

**Mr. Conway:** I have two final points, Mr. Chairman. The first deals with staff. Clearly, there is a major concern felt by all members of this committee that people in the professional and support community at Lakeshore, if this transfer is forced on them, will be provided for. Many of us were alarmed to hear last week that the senior people in the support community, one with 22 or 23 years and someone with just a few years less than that, were at this late date not in any way provided for. The minister's statement indicated that great efforts are going to be made in that connection. It seems that for some at least, and unfortunately for many in the support community, not a great deal is yet apparent.

Can you indicate at this time how many professional and support people from the Lakeshore facility you, with your expanded mandate at Queen Street, could effectively accept and deal with?

**Mr. Fisher:** Could effectively accept?

**Mr. Conway:** And deal with?

**Mr. Fisher:** We requested 358 or 360, in that neighbourhood.

**Mr. Conway:** Total?

**Mr. Fisher:** Total.

**Mr. Conway:** How does that split? Have you any rough idea?

**Mr. Fisher:** Mostly clinical staff. Some few support staff.

**Mr. Conway:** It is not an unreasonable assumption, then, to suggest people in the clinical and professional community at Lakeshore have a much greater expectation of reassignment within this rationalization than those in the support community?

**Mr. Fisher:** To Queen Street, yes.

**Mr. Conway:** We heard from the director of Hamilton, and after his testimony I don't hold much hope for their taking on too many. I have one final point and I want to be very clear on this. As the director of the Queen Street Mental Health Centre, you do not appear to be exhibiting any great degree of concern about what is being given to you. A great number of people, in this committee and elsewhere, have warned us very seriously we are in effect allowing a return to a condition that was more characteristic of an earlier and thankfully past stage in our social development.

I want to be clear that as far as you're concerned, and you have had a very active experience in two of the largest facilities in this province, we will not expect to hear you, either in one way or another, come to us in a year or two or three, if this transfer is effected, pleading for help to be saved from a condition which many very reasonable people have predicted. You don't see in this the possibility for serious difficulty in terms of the long term and immediate term future at your facility?

**Mr. Fisher:** You use the word "possibility." Anything is possible, I suppose, but I don't anticipate this because I think the staff at Queen Street and the clinical staff at Lakeshore are a very fine and capable staff. They've had a lot of experience in dealing with patients. They know how to program for patients. I would not anticipate any return to custodial care or that sort of thing. I think the high-quality program at present



supplied at Lakeshore with this combination can be continued at Queen Street.

**Mr. Conway:** To the extent you can comment, you do not see this transfer and the closing of Lakeshore will have a significant or deleterious impact upon the quality of mental health care provided to the citizens of Metropolitan Toronto?

**Mr. Fisher:** I wouldn't anticipate this, but as you well know, there are many unresolved questions yet. We have yet to design a program or to participate in the design of a program for the after-care in the community. I do not anticipate any deleterious effects.

**Mr. Conway:** When do you anticipate the people of Metropolitan Toronto will know with confidence that these unresolved questions of after-care services will in fact be firmed up and available for all to see?

**Mr. Fisher:** I couldn't give you a definite time, but I would expect we can have at least some of the basic direction work done in a very short period of time. I would think any interim measures taken would be taken to protect the present quality of care. I wouldn't want to understate the difficulties involved. I think it is a difficult task, but I think that with the staff who are working on these problems, we'll be able to successfully maintain the quality of service, and to develop the kind of mental health care that should be provided in Metro. I add here, it's not just Queen Street's problem. Mental health care is not limited to the big psychiatric facilities. Much of the problem is shared by all the health professionals in Metro.

**Mr. Conway:** Would you agree, Mr. Fisher, that with the intended closure of Lakeshore, for many patients and professionals dealing in the mental health sector in Toronto, increasingly that service is going to be related to a very large institutional facility, namely Queen Street? That's going to be the context of the debate.

**Mr. Fisher:** That's a possibility. I think initially what you say is true. I think the long run depends on the kind of co-operative system that's developed. If you want to know what my hopes are, it's that we'll be able to develop a more effective co-operative mental health care system.

**Mr. Conway:** Just finally and in closing, it has to be said, because it has been said here and elsewhere, that many in the mental health field feel that in both the institutional sector and the political community, mental health does not rank as high as it should. Certainly I think all members of this committee are so motivated. I am concerned,

and I know others are very concerned, about those kinds of questions which, at this point, remain unresolved. At any rate, thank you for your evidence.

**Mr. Duksza:** How significantly would the changes following the proposed closure of Lakeshore extend your catchment area?

**Mr. Fisher:** In terms of numbers?

**Mr. Duksza:** Numbers, yes; number of people.

**Mr. Fisher:** I am not absolutely sure of the numbers. I think we at present have in the neighbourhood of 750,000 to 800,000, which comprises Metro and the borough of York—half of North York—so we are up around 800,000 or 900,000, I suppose. Ultimately it will be up around 1,800,000 or 1,900,000, I suppose.

**Mr. Duksza:** By "ultimately," you mean we are assuming what—20 per cent?

**Mr. Fisher:** Well, no. I mean immediately, once we take responsibility for Etobicoke and Peel.

**Mr. Duksza:** Isn't it estimated that 20 per cent of the present catchment area of Lakeshore is going to go to Hamilton? Am I right?

**Mr. Fisher:** My understanding is that Hamilton has been serving half of Halton county and will take the east half of Halton county. It is a relatively lower-populated area.

**Mr. Duksza:** I think it is about 20 per cent.

**Mr. Fisher:** I don't know what the exact numbers are.

**Mr. Duksza:** We are talking right now—this year—about your catchment area of 1,800,000. How many inpatients do you estimate ultimately for the hospital? By "ultimately," I mean if the proposed change goes through within months?

**Mr. Fisher:** We were talking about beds a moment ago and the number of patients. We have 458 beds set up now and, as of April 23, 394 of those beds were occupied, plus 18 on three-days leave of absence or less, which left 46 beds not occupied. So that left us with 174 plus 46, or 220 beds, available. On that same day at Lakeshore there was a total of 181 patients, plus five on three-day visits. Within the alcoholism program there were 19 patients, plus four on three-day visits and 23 patients on the retardation program. Of that, one was on a visit, so there was a total of 47 patients—186 less 47 was 139 patients, and 220 less 139 gives us 81 spare beds. That is the way

it figured for that day and, as you know, Dr. Dukszta, it changes from day to day.

**Mr. Dukszta:** What is the present population of Lakeshore. I am not clear about the full disposal proposed for the present population. Those figures seem to be low as to what they have—number of patients, and so on.

**Mr. Fisher:** All I know is this was the figure that was given me on April 23. On that day, they had a total of 181 patients, plus five on three-day visits.

**Mr. Dukszta:** I know the number of in-patients at Lakeshore is now big enough, so I'm assuming that some of them will be discharged into the community. But they have not had much final success discharging that ultimate last group. I think you are probably somewhat underestimating the figure, but let me leave it at that.

McKinsey suggests the increase in the catchment area over the next five years will be of a certain size and then, in 10 years, even more. Do you remember the exact figures suggested?

**Mr. Fisher:** Seventeen per cent for Queen Street and 27 per cent, or something like that, for—

**Mr. Dukszta:** Well, now the 17 and 27 per cent will all be yours, if we fail to stop it. So how much is that—that is, in five years' time?

[4:30]

**Mr. Fisher:** If I may respond to your previous comment, the figures I gave you were not estimates. They were census reports, and the 186 was a census report figure.

**Mr. Dukszta:** If everything were transferred as of today you would still have a number of vacancies.

**Mr. Fisher:** We still have a number of beds available.

**Mr. Dukszta:** But in five years' time the increase is what? Over 20 per cent for the Lakeshore area and—

**Mr. Fisher:** If you assume we're going to continue a program with 1977 standards into the future, then we could expect an increase, but that's apparently what was built into the McKinsey report because the study of systems was not included within the terms of reference.

**Mr. Dukszta:** I looked through the report. It's not what I would describe as a complete systems study, but it did interview people from general hospitals.

**Mr. Fisher:** That's right.

**Mr. Dukszta:** I even noted that they talked to general practitioners, so in effect they made a stab at, not a completely methodologically correct, but a semi-comprehensive stab at a systems approach to the delivery of psychiatric care, Mr. Fisher, I would say.

**Mr. Fisher:** I was quoting from the letter of introduction in which it stated that the study of the system as a whole, that is the total mental health care system, was not within the terms of reference and obviously they couldn't study the psychiatric hospitals without taking some look at the general hospitals.

**Mr. Dukszta:** But of course, just as an aside, they are all of the hospital type of patients. There's a whole section on it. In that sense I would say they did. I mean the last complete study of the system was the joint commission report in the United States, which was some time ago. That was a much cheaper study and they did, I would say, a very good job. At least all of you professionals in three hospitals thought until quite recently that it was a very good job that applied to what you thought were the needs and everything else.

Back to 1885: How many beds, if we accept the McKinsey figures, would you need then to take care of the joint area?

**Mr. Fisher:** 1985.

**Mr. Dukszta:** Sorry, sorry. I'm so historically minded. I did not want to go to 1984.

**Mr. Fisher:** I'm not prepared to give you a figure, but I would say that given the number of beds we have, we would rely on the development of a co-operative mental health care system to take up any growth. As I've said before, in Hamilton and Scarborough the numbers of admissions to the psychiatric hospitals are quite reduced compared to what we're presently admitting at Whitby and Lakeshore. That is apparently because of the number of first admissions that these hospitals—the hospital in the Hamilton area and the two hospitals in the Scarborough area—are taking.

**Mr. Dukszta:** I accept what you're saying, but that still applies to today. At the moment we're talking of a 33 per cent to 34 per cent increase in catchment area—a concomitant increase in the admission of a third over a period of a decade, and that's cumulative. Could you tell me how many beds do you think you will need? You have now, what, 700 or whatever it is. How many beds will you need in 10 years, time, provided you're still an administrator, whoever your successor is, et cetera. I think we have to think in those terms. Maybe you don't have



to think of it, but we do have to think of it if we're thinking of the role differentiation between psychiatric units and psychiatric hospitals and discussing closure of one major facility.

**Mr. Fisher:** Dr. Duksza, I'm a real optimist. I think the capacity we have in Metro for developing a co-ordinated system is very great and I suspect we won't need any more beds by 1985 than we have at present.

**Mr. Duksza:** I share entirely your optimism in the health professionals. But suppose everything just goes really bad on us and this comprehensive system does not develop. Could you tell me how many beds we would need, do you think?

**Mr. Fisher:** I think I'd refer you to the McKinsey report.

**Mr. Duksza:** Good.

**Mr. Fisher:** They've done a good job of predicting it based on what is at present happening and what was happening in 1977.

**Mr. Duksza:** I just want to check for one second. Eight hundred and sixty-two is very minimal by 1987. You were involved in the McKinsey report. I think when Mr. Conway was questioning you, you said you were quite directly involved in it, weren't you?

**Mr. Fisher:** I was on the steering committee.

**Mr. Duksza:** A number of people from Queen Street were on the steering committee, or did they just give submissions and things?

**Mr. Fisher:** Just the administrators of the three facilities were on the steering committee, but I think the staff from Queen Street had many opportunities to give submissions.

**Mr. Duksza:** So was there, as in our system here, a minority and a majority report offered? Was there a minority report to McKinsey which you could mention even if it were never published, or were you all in agreement, in fact?

**Mr. Fisher:** I think the kind of approach the consultants made was merely to obtain facts. They asked a number of questions; we tried to answer their questions as well as we could. I must suppose that many of the answers were the opinions of staff, but it was merely our task to answer the questions that were put to us and that's all we did.

**Mr. Duksza:** But you were yourself a member of the steering committee?

**Mr. Fisher:** That's right.

**Mr. Duksza:** Then I don't understand fully the role of the steering committee. Before the report came out, did you look at it?

**Mr. Fisher:** When the firm was retained it checked with the steering committee from time to time. We gave interim reports and projections.

**Mr. Duksza:** Okay, so when you got one of the interim reports, because there were a number of them—in fact I got a brown envelope once—were you in agreement with those recommendations as the committee reports went along?

**Mr. Fisher:** First of all I hadn't anticipated the closure of Lakeshore at that time.

**Mr. Duksza:** I didn't think so.

**Mr. Fisher:** I was in full agreement that Queen Street's beds should be fully utilized and this, as you know, is one of the considerations built into the report.

**Mr. Duksza:** But as you said, you did not anticipate it because in effect the McKinsey report was an emanation of the thinking of the professionals in the field and, of course, no one thought of it as a good or reasonable methodologically sound solution to the problem. So naturally you never thought of it. When did you think that it was a good idea? Could I ask an embarrassing question?

**Mr. Fisher:** I think given the terms of reference they had, they did a good job.

**Mr. Duksza:** Yes, I thought so too actually, I think they did a very good job. But, of course, now the decision reached by the government, right now by the minister is in direct contradiction to what has been suggested by a very reputable body and a body of a number of professionals who have worked hard on it. They suggest of course that by 1987 you will need many more beds. They also are concerned that the catchment areas will not be too big. They're concerned about the role differentiation. They're concerned about a number of things which now have not been in fact accepted by the minister.

Am I correct that you said to Mr. Conway that you knew about the closure of the Lakeshore only when the minister announced it?

**Mr. Fisher:** That's correct.

**Mr. Duksza:** So that you're now part of Dr. Lynes' post-partum committee, aren't you?

**Mr. Fisher:** One of our employees is a member of Dr. Lynes' committee. I am not a member.

**Mr. Duksza:** You're not a member yourself?

**Mr. Fisher:** I'm not a member.

**Mr. Duksza:** Sorry, just a member from the—



**Mr. Fisher:** That's right.

**Mr. Duksza:** Good. I think that's maybe the best.

**Mr. McClellan:** Most of the areas that I wanted to have information on have been covered, Mr. Chairman and Mr. Fisher. Could I just go back for a second to the issue that McKinsey identified? The option which McKinsey rejected, but which you have indicated you are following—that is, to make these so-called difficult beds at Queen Street, in using McKinsey's phrase, available to accommodate both the transfer of patients and the additional case load from the enhanced catchment area—I'd like to get as clear a sense as possible of the programs that were moved or relocated in order to achieve that target of 174 available beds. In September 1977 McKinsey indicated there were 78 easy beds and 138 difficult beds. When you began the process of setting up additional beds to accommodate the closure and the transfer, how many of your beds were initially rated as easy, that is to say, beds that didn't require shifting of program or patients, out of that 174 that you eventually achieved?

**Mr. Fisher:** This depends on how you calculate the beds; 174 beds, as I said before, includes some of those beds on wards that have not been set up. For example, we have a ward with a 34-bed capacity; we may not have 34 beds on that ward, so that would be part of the figure for 174.

Prior to our taking patients from Lakeshore we had 416 beds set up.

**Mr. McClellan:** That was as of the end of December.

**Mr. Fisher:** That's right.

I think the McKinsey study indicated some of the beds would be difficult because they were located or would have to be located on wards that were actually being used for day-care programs, this sort of thing. Obviously with the change proposed, we will be required to find new places for some of those day-care programs. As I stated before, we have quite a lot of space in the basement areas and also we are hoping to relocate or to establish more satellite units in the community, especially in the Lakeshore area, when we know what the final recommendation of Dr. Pat Lynes' committee is.

**Mr. McClellan:** Right. How many of the 174 were in the difficult category—that is to say, difficult by virtue of the fact that they were already being used for something, or the space was already being used for something of that—

**Mr. Fisher:** As I recall, they said in the report there were about 68 beds or 78 beds that were easy.

**Mr. McClellan:** So the data from the McKinsey report continued to be valid until December 1978, more or less.

**Mr. Fisher:** You have to take into consideration how they obtained their information. They had two people who visited the various wards and services and talked to staff. They asked them what their opinions would be about programs and they concluded, as a result of their conversations with staff, that it would be difficult to relocate some of these programs. It is difficult; you have to change your whole concept of planning. It's not easy but it is surely not an impossibility, and from what I have been able to observe at Queen Street, the staff have rallied to this challenge very well and have prepared practical plans that can be implemented and should be successful.

**Mr. McClellan:** Right. No, I understand that. I am just trying to get an idea of the number of beds that were made available through that process; out of the total of 174, how many were made available by moving current programs?

**Mr. Fisher:** I couldn't give you the exact numbers really.

**Mr. McClellan:** A ballpark figure?

**Mr. Fisher:** I'd say 68 maybe, 70.

**Mr. McClellan:** Were difficult.

**Mr. Fisher:** Difficult. We are dealing with variables here, you know. It's also a matter of opinion as to how difficult these changes are.

**Mr. McClellan:** At any rate, a statement which reads as follows, "The number of inpatient beds that Queen Street Mental Health Centre can make available without relocating any current programs is 166," I assume from what you said, isn't accurate.

**Mr. Fisher:** As I said, I didn't have the figures immediately available before me here, but totally we had, exclusive of the Metfords unit, 632 beds and we had 416 beds set up. If you subtract 416 from 632, 216 beds are available. Yes, it might be difficult to make some of them available, but not impossible by any means.

[4:45]

**Mr. McClellan:** The other question is partly rhetorical. I wonder what is the basis of your incredible optimism around the kind of fundamental redesign of the mental health care system that would nullify the McKinsey need projections?

**Mr. Fisher:** Twenty-five years of experience in the mental health field is one basis. I have worked in quite a few hospitals, and I know these things are variable. I once worked in a hospital where we were required to take 82 patients from another hospital. I want to tell you, they looked for the most chronic patients they could find to transfer. As it happened, it was a new facility similar to Queen Street. Within a year there were only three of those patients left in the hospital.

From my experience, change is sometimes very good for patients. It is remarkable what might occur. Another basis for this optimism, as you put it, is what I have been able to observe of the Hamilton program and even segments of the Metro program, particularly in the Scarborough area. They have done remarkable things through co-operative planning. It seems to me if it is possible in Scarborough and Hamilton, it ought to be quite possible and feasible for Metro.

**Mr. McClellan:** We are talking about a redesign that would obviate a 64 per cent increase, give or take a couple of percentage points—a 27 per cent increase for Queen Street projected for 1987, and a 37 per cent increase for Lakeshore. So we lop off those parts of the Lakeshore catchment area that don't come into your new catchment area. We are still talking about a projected increase—although I can't get my hands on the precise break-out of that 37 per cent figure—in need for inpatient beds from McKinsey in the order of 50, 55 or 60 per cent.

**Mr. Fisher:** Your percentages seem very high to me. I don't recall reading those figures in the McKinsey report. As I said before, I believe the McKinsey company assumed the ratio of service provided in the community, and the kind of service provided in the community, would be fixed over the next 10 years, and that the psychiatric hospitals would continue to provide approximately the same kind of service over the next 10 years. But they added the caveat that if the system changed, they could not predict what the result might be.

It seems clear to me that if you read the McKinsey report carefully, they are acknowledging that with a change in the system, a change in philosophy in dealing with patients, their figures would not necessarily be valid. I believe this is why they have referred several times in the text of their report to the fact that although they did study the system in part, as Dr. Duksza has already pointed out, they did not undertake any extensive study of the system as a

whole with the purpose of recommending an ideal system.

They in fact said, "Well, given the way the thing has been put together informally, the Metro system is working quite well, so let's project it into the future."

**Mr. McClellan:** The problem for me as a member of this committee is to try to deal with, when you come right down to it, the projections that McKinsey cited, based on the system as it was when he studied it. Granted, I see that.

What I am quoting from is section 6-2 of the report, where they conclude that the effect of a number of factors—demographic trends, admission rates over a period of time, et cetera—"would be to increase demand on Queen Street and Whitby about 27 per cent, and on Lakeshore 37 per cent."

I come back to my dilemma as a member of the committee which is to try to understand what our options are. You have stated a faith in a kind of system design that will accommodate and obviate the need for you to provide bed space on the basis of the present system, or on alterations of the present system. But I don't know what those alterations are, where they are, where the plans for them are or what the key components of that system redesign are.

**Mr. Fisher:** As McKinsey pointed out in the report, there is an overlap. It is not as if there is a certain group of patients admitted or treated only by the general hospitals or community agencies and that then there is a completely separate group treated by the psychiatric hospitals. I think what they say is true; the more difficult patients tend to be treated by the psychiatric hospitals, the longer-term patients tend to be treated by the psychiatric hospitals, given the way the system is designed at present.

There is an overlap, and it is in this area of overlap where there is much to be gained; as I understand it, in Hamilton and Scarborough the general hospitals' psychiatric units are taking a much more active role than in Metro right at the moment. They are admitting more first admissions.

The figures in Hamilton are really quite startling, when you consider the size of the catchment area.

**Mr. Turner:** At the possibility of being a bit repetitious, Mr. Chairman, I would like to ask Mr. Fisher a specific question, or refer to a reply which he gave to a specific question. As I remember it, I think the question was, "What in your opinion would the total or overall effect have on the mental health care system?" to which you replied that you



hoped a better system of mental health care would evolve. What do you mean by "a better system"?

**Mr. Fisher:** One of the preoccupations of staff at Queen Street, and I dare say at Lakeshore, has been the welfare of the patients. There is considerable concern that patients' needs are met, that they are normalized, if I could put it that way, and that they are helped to live as normal a life as possible.

One of the worst things that can happen to you, I assure you, is to become institutionalized. I think most progressive mental hospitals attempt to avoid this. Even as fine an institution as Queen Street is at best an institution; it is not like living in a normal home. Eighty per cent of our patients who are discharged during the year go back to their own homes; about 20 per cent of those discharged, we have to find help for in the community.

It would be my hope that we could avoid admitting more patients, or other means might be developed through the general hospital psych units or other facilities in the community or perhaps through satellite units where patients' needs could be met sooner so that we could avoid admissions. I think this would be a fine program, if it could be developed. There is good reason to expect that it could be developed because with the development of satellite units at Queen Street and Lakeshore there was a decrease in demand for inpatient beds.

**Mr. Turner:** I am quite interested in this. If I may follow up, I interpret what you are saying to be that institutions, such as Queen Street, are going to play a lesser role, and that a more important role perhaps will be taken up by the community agencies, the general hospital psych units and that kind of facility.

**Mr. Fisher:** Yes. A lesser and lesser role as a domiciliary facility, but a more active role in the co-ordination and planning of services. I think where Queen Street has to develop is to develop more active planning with the community, and I dare say the more space you have the less pressure there is to plan.

**Mr. Turner:** I suppose that is true. Just to follow that up, is anybody taking the lead in that type of planning or even having meetings to discuss this?

**Mr. Fisher:** The Queen Street clinical staff have done quite a lot of this in the past and I suppose the Lakeshore staff have too, but I really don't know what has been done at Lakeshore.

For example, we have a housing com-

mittee at Queen Street which has done a remarkable job of setting standards for using board-and-care facilities. We don't dump patients; we actually very carefully select the homes. Maybe they aren't all the kinds of places we would individually like to live in, but they are clean and decent. We have established standards for our own staff to follow. I could submit a copy of our housing committee report, if you would like, for the use of the committee.

This kind of thinking that has been developed over the past several years is to the credit of the staff at Queen Street and, followed through to its logical conclusion, I think it could result in a more humane treatment program.

**Mr. Turner:** We seem to be zeroing in on projecting the possibility of a shortage of beds within Queen Street, given information as of today or as of a few days ago. Would you agree that the treatment for mental health patients would continue along present lines and in fact, getting back to what you have just said, that there may be even less requirements for beds at Queen Street than there are today?

**Mr. Fisher:** That would be my hope. There has been a remarkable decline in the past several years in the need for beds, and this has been in the face of an increasing population. I don't know whether we have bottomed out, as some people say, or not. I think whether we bottom out depends on how we use the resources that are available. There is a disadvantage in running a place half empty. I am not so sure that making a place half empty or a quarter empty is all that stimulating to the staff there. I rather think that operating a facility at 80 or 90 per cent capacity, in conjunction with the other mental health professionals and agencies in the community, gives you a maximum opportunity to develop the potential.

**Mr. Turner:** I can understand that. Just for personal information, is Queen Street an accredited hospital?

**Mr. Fisher:** Yes, it is. It has been for several years.

[5:00]

**Mr. Chairman:** Dr. Duksza, did you have a supplementary?

**Mr. Duksza:** Yes.

**Mr. Chairman:** Or would you prefer to go to the bottom of the list?

**Mr. Duksza:** I will go to the bottom of the list.



**Mr. Sweeney:** Mr. Fisher, you have referred on several occasions to a different, I gather you were saying, system design in the Hamilton and in the Scarborough area. Did I catch you correctly? You seemed to be saying that in those geographical areas they were dealing with mental health patients in a different way than we are at present doing at either Lakeshore or Queen Street; is that an apt interpretation of what you said?

**Mr. Fisher:** Yes.

**Mr. Sweeney:** Do you have any evidence that that different way of dealing with patients in those two areas is less effective, that patients with a mental illness are not as well treated, dealt with, served?

**Mr. Fisher:** No, I don't.

**Mr. Sweeney:** Is that the basis then for what has been referred to several times as your optimism? That there probably are better and more effective ways of dealing with the whole problem, not just with the hospital itself?

**Mr. Fisher:** Yes. It is not new, you know. At Queen Street the programming has been emphasizing community care for several years. What I am saying would be merely a logical extension of the trend that has been developing there for a long time. So the key to the problem is co-operation between general hospitals and psychiatric hospitals. I could give you an example with nursing homes where the aged my have psychiatric problems from time to time.

I think, if I am not mistaken, there was a rule that if a nursing home patient is away for more than three days or something they have to be discharged. Sometimes this makes a psychiatric facility a little reluctant to accept a nursing home patient because then they become a nursing home patient in a psychiatric facility because it is hard to get them back into a nursing home again.

**Mr. Sweeney:** Right.

**Mr. Fisher:** Now, say this period of leave of absence were extended for eight days; it would be quite possible for the psychiatric facility to stabilize the patient and get him back into the nursing home. Then we could develop a supportive relationship with the nursing homes that would make it possible for them to continue their life in a nursing home environment. It is this kind of co-operation that would be very helpful.

**Mr. Sweeney:** Okay. I thought you referred very early, in response to another question, that at one time there were 1,200 institutionalized patients at—was it at Queen Street?

**Mr. Fisher:** That is a guesstimate. I am not sure how many it was, but it was in that neighbourhood.

**Mr. Sweeney:** It was very high.

**Mr. Fisher:** Yes. That was when the old building was there.

**Mr. Sweeney:** Okay, and now the figure you gave us was something slightly in excess of 400?

**Mr. Fisher:** That's right.

**Mr. Sweeney:** That is over a period of time when the population, in fact, is increasing, or at least had been increasing?

**Mr. Fisher:** That is true.

**Mr. Sweeney:** So we have an inverse movement. The total population and consequently the potential number of mentally ill people is going up, but the actual number in the hospital is going down dramatically.

**Mr. Fisher:** Yes, it has. Until the last few years, it has pretty well levelled off. I have a chart here which I—

**Mr. Sweeney:** That was going to be my next question.

**Mr. Fisher:** It had levelled off. At Queen Street you could see the population on a month-by-month basis followed that kind of curve.

**Mr. Sweeney:** How long a period of time was that curve?

**Mr. Fisher:** It was 1974 through 1979.

**Mr. Sweeney:** About five years?

**Mr. Fisher:** Yes.

**Mr. Sweeney:** So it was relatively constant according to that?

**Mr. Fisher:** It has been relatively constant. At one time last year we had dropped to 289 patients in Queen Street; but part of that 400 includes 40 patients transferred from Lakeshore.

**Mr. Sweeney:** Oh, already transferred?

**Mr. Fisher:** Already transferred, yes.

**Mr. Sweeney:** So, without the transfer, the population of Queen Street would be below 400?

**Mr. Fisher:** Yes. We were running an average of 320 to 330 all last year.

**Mr. Sweeney:** You referred earlier to two floors, I think, in one of your towers, or the equivalent of two ward areas that had been taken over by forensic sciences.

**Mr. Fisher:** Yes.

**Mr. Sweeney:** Was that deliberately built into the design of the building from the beginning, or was that use made of it as it

became apparent that it was not going to be needed?

**Mr. Fisher:** I think the latter. That use was made of it because the space was there and was not being used.

**Mr. Sweeney:** If needed, could that space be recovered? Is there any good reason why it could not be recovered, let me put it that way?

**Mr. Fisher:** I do not think I could comment on that. I understand Metropolitan Toronto's forensic services program is very vital to the courts.

**Mr. Sweeney:** I wasn't suggesting the service could be discontinued.

**Mr. Fisher:** If a suitable relocation could be found, of course, but there is no speculation and no intention to make that change, as far as I know.

**Mr. Sweeney:** Okay: If you were to compare the west Metro area, at present being served by Lakeshore and Queen Street and now to be served by Queen Street alone, with most other comparable regions in the province—Hamilton, London, Windsor, Ottawa—how would they relate? Could you give me a ballpark view of it?

**Mr. Fisher:** I am not sure I understand your question.

**Mr. Sweeney:** Take the four or five major urban areas of the province—Ottawa, Hamilton, London, Windsor—other than Metro and not even going into the north because I realize there are particular circumstances to be taken into consideration in the north. Consider the number of people they serve, the distance people have to travel, the difficulty or lack of difficulty of getting living accommodation for outpatients. Is west Metro unique in the province? Is it better served, worse served, roughly comparable? In the scale of values, where would you put it?

**Mr. Fisher:** I suppose it is roughly comparable. I think it is difficult to find boarding home facilities in west Metro because of the bylaws and ordinances. This is one reason there are so many patients in board-and-care facilities in the city of Toronto.

**Mr. Sweeney:** Again, you are comparing it to those four or five other urban regions I mentioned.

**Mr. Fisher:** I am not an expert. I really should not comment. I don't think I could comment.

**Mr. Sweeney:** I asked the question, Mr. Fisher, because of your long experience in the business. Particularly since you have

been in three or four different hospitals, I thought you might have a fix on that.

**Mr. Fisher:** I was the administrator at Lakehead Psychiatric Hospital at one time. The problems there are vastly different because they cover an immense space.

**Mr. Sweeney:** That is why I did not ask you to make a comparison with the north; I appreciate it is a different set of circumstances. But what I seem to hear you say, and do not let me put words in your mouth, please, is that if you take the five or six major urban areas of this province and we look at what Queen Street is now going to serve, there would not be a significant difference.

**Mr. Fisher:** I really do not know; I could not compare Ottawa with Metro because I am not that familiar with Ottawa. But I should not think there would be that much difference.

**Mr. Sweeney:** How many mental centres are there in Ottawa, do you know, in the Ottawa-Carleton region?

**Mr. Fisher:** I do not know how many hospitals there are. I think there is one major regional centre there.

**Mr. Sweeney:** I mean a hospital like—

**Mr. Chairman:** Mr. Sweeney, I think we are going to have somebody from Ottawa later on. I do not think Mr. Fisher should be expected to give views and opinions related to Ottawa.

**Mr. Sweeney:** I was trying to make a comparison, Mr. Chairman. I am not particularly interested in Ottawa per se.

**Mr. Chairman:** In order to make a comparison, though, one has to have certain information.

**Mr. Dukszta:** Could I suggest that the bed ratio for Metro is 0.29 per thousand, and it is 0.65 for the rest of Ontario, so it is a significant difference.

**Mrs. Campbell:** Supplementary to the statements of Mr. Fisher about his housing committee, I would like to have his comment, and I am sorry I do not have the correspondence with me. I have been searching for it. I expressed concern to both Mr. Sewell, the mayor of Toronto, and to the minister concerning the lack of any kinds of standards for these homes, particularly in the Parkdale area. The minister replied, as I recall, and I will put it on record if I am wrong, that Queen Street did not recommend any homes for psychiatric patients; in any event, not in the south Parkdale area. Would you care to comment on that statement?

**Mr. Fisher:** My comment is that we are using homes in the Parkdale area.

**Mrs. Campbell:** And you are recommending?

**Mr. Fisher:** Again, I am not in the business of selecting these homes per se.

**Mrs. Campbell:** I am not suggesting that, but you have made reference to your committee.

**Mr. Fisher:** Yes, we recommend some homes in the south Parkdale area as being suitable for placement of patients because they meet the criteria of this housing committee report.

**Mrs. Campbell:** I see. So in fact there are some that you do recommend?

**Mr. Fisher:** Yes.

**Mrs. Campbell:** And there are some instances I presume where patients—I think the minister pointed this out—are not under any obligations to go into any specific homes? If they find themselves in one that is less than desirable, it is more or less on their own initiative?

**Mr. Fisher:** Eighty per cent of the patients we discharge either return to their own homes or find their own accommodation—as they wish. We have no control over this.

**Mrs. Campbell:** We understand that. But aren't you concerned with all this talk about de-institutionalizing patients and the rest, and particularly with your increased role at Queen Street, that there should at least be some person somewhere with some responsibility for standards for these places to which patients are discharged?

**Mr. Fisher:** We are concerned with standards. That is why Queen Street formed the housing committee and why the committee put out its report as a guide for Queen Street staff.

**Mrs. Campbell:** Exactly. I think you are aware of the very difficult situation, because the ministry seems to say that it is up to the city of Toronto to assess the standards and maintain them. The city, of course, takes the position that the ministry ought to have standards established, and you are in between. Have you any comment about the standards, as you see them?

**Mr. Fisher:** Yes. I think that if Queen Street Mental Health Centre staff is involved in placement of a patient in a boarding care facility or any facility, then to the extent that we are influencing that person, we have a responsibility to establish and maintain a standard.

**Mrs. Campbell:** But would you go beyond that to the point where, if you adopt a philosophy of more and more people being de-institutionalized—and I have nothing against that philosophy—you agree that you have a responsibility greater than just choosing places you are actively engaged in recommending; where perhaps you might be looking at what is available for these people once they are discharged?

**Mr. Fisher:** Actually, this is what this recommendation covers.

**Mrs. Campbell:** I am aware of that.

**Mr. Fisher:** It covers standards for private boarding homes. It also deals with links between city hall and the private boarding homes. It also deals with the kind of after-care programs and the standard we would recommend for the supervisors of boarding homes.

**Mrs. Campbell:** I am aware of that report and I have met with some of the people involved.

**Mr. Fisher:** I know you have.

**Mr. Dukszta:** Do we all have a copy of that report?

**Mrs. Campbell:** I do not know. I have not been here for these meetings.

**Mr. Dukszta:** Which report is it? I am so sorry; I did not get it.

[5:15]

**Mr. Kennedy:** It is entitled, The Queen Street Mental Health Centre Policies and Procedures re Outpatients Residing in Private Boarding Homes.

**Mr. Kerrio:** Can we have a copy of it?

**Mr. Chairman:** Yes. We'll have it photostated, Mr. Fisher, and give it back to you.

**Mrs. Campbell:** Regardless of what Queen Street does or what Queen Street recommends, somebody has to take some responsibility ongoing above that, would you not say, if you're going to have your complete mental health care package?

**Mr. Fisher:** Yes, definitely. There should be standards. Of course, that's why we are interested and involved. That's why we say if we influence a patient we certainly must be sure that our standards are appropriate.

**Mrs. Campbell:** I don't want to put words in your mouth but where would you believe those standards should flow from—a municipality or the provincial government concerned with mental health?

**Mr. Fisher:** I honestly haven't speculated about that.

**Mr. R. F. Johnston:** Were you involved in



any evaluation of the McKinsey report after it was actually made public and passed around?

**Mr. Fisher:** No, sir.

**Mr. R. F. Johnston:** You talked a lot about planning, the co-ordinated planning in the health care field, and obviously the ministry has to be an essential part of that as well, it would seem to me, in making health policy and funding health dollars. Would you agree with that?

**Mr. Fisher:** I am not an expert in overall health planning, but it sounds all right the way you put it.

**Mr. R. F. Johnston:** You need bucks to do these things, generally speaking.

**Mr. Fisher:** Yes, you need bucks to do it.

**Mr. R. F. Johnston:** Do you think this kind of pressured planning has happened because you announced the closing and then decided your hospital and the community around the old Lakeshore hospital have to adjust to this after the fact? Is that the way this kind of co-ordinated planning should be developed?

**Mr. Fisher:** I don't have any comment on that. I rather suspect it was unavoidable under the circumstances. I mean, after all, the decision has to be made and although I'm not involved in the decision process I can understand the way it happened.

**Mr. R. F. Johnston:** Right. In looking at the decision-making in terms of Metro Toronto, the McKinsey approach of looking at the three hospitals and doing those three catchment areas together makes a lot of sense, I would think, such as looking at their combined services.

**Mr. Fisher:** Yes, I think they were selected because each of those three hospitals provided service to Metro Toronto.

**Mr. R. F. Johnston:** Right. It would therefore seem logical to me that the same philosophical approach would be made in making a decision about the continuation of each of those hospitals, in that you would not use one approach for one hospital and another for another hospital. What I'm leading up to is the fact that Whitby is at present being rebuilt on exactly the basis, or close to the basis, a little more in fact, that was suggested in the McKinsey report. Yet Lakeshore is being closed contrary to those same approaches, same recommendations. Does that seem to you to be consistent or to follow?

**Mr. Fisher:** As I said before, I think if

you study the McKinsey report carefully you'll find the statement was made at several points that it wasn't within the terms of reference of the company to study the system design. They said, several times, that if the system were to change it would tend to throw a question on the validity of figures. It seems to me the decisions are related but not necessarily from the standpoint of the same reasoning, if you will.

**Mr. R. F. Johnston:** But the ministry, in the end, and the minister are the ones who made the decisions on this and he has decided to discount one portion and accept another. He has told us, in point of fact, just for your information, that his decisions were based purely on the McKinsey report, a few other documents which he tabled with us, and discussions.

**Mr. Fisher:** Sir, I'm not speaking for the minister, I'm merely speaking from my own point of view and what my view of this is.

**Mr. R. F. Johnston:** My follow-up from that is if you're talking about a general move towards this more optimistic approach to health care in Metro, it seems to me that should include in our planning overview Whitby as well, and yet the approach for Whitby is on the development of population need that McKinsey suggested. What's happened with Lakeshore is it's being closed. That, to me, is fundamentally inconsistent.

**Mr. Fisher:** That's your statement, I have no comment on that.

**Mr. R. F. Johnston:** No comment, okay.

**Mr. Duksza:** The fifth amendment.

**Mr. Fisher:** The fifth amendment, that's right.

**Mrs. Campbell:** That's unfair.

**Mr. R. F. Johnston:** There are a couple of other things I would like to have some clarity on. Did you say there is a maximum of 632 beds at Queen Street at the moment?

**Mr. Fisher:** That's right, exclusive of the 68 which are used now for Metfors.

**Mr. R. F. Johnston:** Right. Were there 394 patients at Queen Street and 139 at Lakeshore at that census time?

**Mr. Fisher:** On April 23, we had a total of 394 plus 18 on visit.

**Mr. R. F. Johnston:** Were there 139 at Lakeshore?

**Mr. Fisher:** That's correct.

**Mr. R. F. Johnston:** So combining those, there would be 533 not counting those who were on visit?

**Mr. Fisher:** That's right.

**Mr. R. F. Johnston:** What is the reasonable rate of occupancy that is accepted in terms of running a hospital at this point? The figure I've been given is 85 per cent. Do you accept that?

**Mr. Fisher:** I don't know whether I would or not. It varies. The rate of occupancy is an average, isn't it? It depends on the fluctuations, of course. If you were to develop a program where you had many patients on visit, for example, and I've seen some hospitals with far more patients on visit than Queen Street, then you would, over the weekend, have a tremendous drop in the census. It's like how tall should you be? Your legs have to be long enough to touch the floor. I'm not so sure 85 per cent has any magic qualities about it.

**Mr. R. F. Johnston:** It's just that I notice when you take 533 beds already filled, knowing what you're getting from Lakeshore, that is 84 per cent occupancy right there.

**Mr. Fisher:** It's getting up there.

**Mr. R. F. Johnston:** I have a further question to do with the various outpatient services. It is mostly information and I'm not exactly sure of the status of these.

Our indication from the minister in the House was the following services would be transferred directly to Queen Street: Adolescent services, inpatient and day care.

**Mr. Fisher:** From the Lakeshore?

**Mr. R. F. Johnston:** From the Lakeshore.

**Mr. Fisher:** No.

**Mr. R. F. Johnston:** Oh, I'm sorry. They're just relocating these within your present building?

**Mr. Fisher:** I know nothing about this.

**Mr. R. F. Johnston:** Okay, so there is no point asking anything further about any relocations. Who is deciding that?

**Mr. Fisher:** I believe Dr. Pat Lynes is chairman of the committee. We have appointed one of our staff to be a representative on that committee. I believe the committee report was received on April 20, and I don't know the content of that report.

**Mr. R. F. Johnston:** Are these the services for which you are talking about the space being available?

**Mr. Fisher:** No, these are the Lakeshore residents.

**Mr. R. F. Johnston:** Okay. What about the ones who are being left at Lakeshore? Have you thought at all or envisaged the

administration of those programs that are now thought to be maintained at Lakeshore?

**Mr. Fisher:** We haven't really reached the point of discussing specifics of administration. We've appointed a program planning committee and I think we've discussed some of these questions, but until we actually know what the final outcome will be, we can't very well design the administration. It doesn't appear to us to be a monumental problem or anything.

**Mr. R. F. Johnston:** I was just wondering.

**Mr. Fisher:** For example, we're at present doing laundry for Lakeshore. We've been doing it for years. Whatever is left there, compared to what they have now, or have had, will be relatively small and it shouldn't be much of a problem.

**Mr. R. F. Johnston:** I guess I was just looking to see what your immediate reaction was. Would you probably administer directly from Queen Street rather than Lakeshore?

**Mr. Fisher:** Oh, yes, we probably will. For example, if the alcoholism program is left there, we would provide whatever services are necessary. It might mean we'd have a small office for a clerk and clinical records—that sort of thing—but it's no real problem.

**Mr. R. F. Johnston:** Another question, primarily for information; it has to do with the psychogeriatric ward. As I understand it—and it has been referred to in my note as the 1956 building?

**Mr. Fisher:** That is correct.

**Mr. R. F. Johnston:** There are to be up to about 100 beds?

**Mr. Fisher:** The original plan was that there were two wards for 50 beds each.

**Mr. R. F. Johnston:** Is that how they were established before; was that the maximum number that was envisaged?

**Mr. Fisher:** It's the maximum number of beds. At present we are running each of these wards with 35 beds.

**Mr. R. F. Johnston:** There would be no crowding, in your view?

**Mr. Fisher:** Far from it.

**Mr. R. F. Johnston:** Okay, fine. I think those are all my questions—no, there's one more. Grant here has a fetish about parking space, and I thought I would ask you about the effects of the new staff and visitors who would be coming to Queen Street. Would there be any recreational space at Queen Street, any outside space not now used for parking, that would have to be

taken or usurped for parking to accommodate new staff and visitors?

**Mr. Fisher:** We think we'll have to put in another parking area. At present we have 298 parking places, and we're discussing putting in another parking area of about 100 spaces in the southeast corner of the grounds. Mind you, we have 27 acres; I don't think it's going to put any pressure on our recreation space per se.

**Mr. R. F. Johnston:** Okay: Those are all my questions.

**Mr. Chairman:** Thank you very much, Mr. Fisher. We hope you haven't found the session too onerous.

**Mr. Fisher:** I enjoyed it; thank you.

**Mr. Chairman:** Thank you. I need the committee's direction. We have 35 minutes left and we have a number of witnesses from whom we have to hear: Mrs. Jones, Mrs. Latimer, Dr. Anderson; and Dr. Durost is here as well I believe. Obviously we're not going to be able to do them all. Is Mrs. Latimer here? Mrs. Jones? Would the committee agree to hear from Mrs. Latimer and Mrs. Jones, and perhaps we could reschedule Dr. Anderson and Dr. Durost?

**Mr. McClellan:** I wonder if we could start with Mrs. Jones from the Peel Social Planning Council? They were in attendance on Wednesday and came back again today. Rather than having to risk the chance of them having to come back for a third day, I wonder if we could start with them and then hear Mrs. Latimer.

**Mr. Chairman:** As long as the committee would agree to complete both; I think Mrs. Latimer has been here before as well and, to be fair, I think we should complete both. If the committee will agree to do that, we can proceed.

Mrs. Jones and then Mrs. Latimer? Would that be satisfactory? We could divide the time, which would mean that perhaps we could go to 5:45 or 5:50 and then spend the remaining time with Mrs. Latimer.

**Dr. Anderson:** The other two witnesses aren't needed?

**Mr. Chairman:** Are you Dr. Anderson?

**Dr. Anderson:** Yes.

**Mr. Chairman:** If it isn't inconveniencing you too much, sir, perhaps we could reschedule your appearance for next Monday. We have a full day tomorrow and a full day on Wednesday, and I need the direction of the committee. Next Monday would appear to be the logical date.

**Mr. Boddington:** I believe the minister is anticipating appearing last before the committee as a summing-up position.

**Mr. Duksza:** The minister would like to sum up when we haven't even fully heard everybody?

**Dr. Surplis:** Oh, we'll sum up.

**Mr. Duksza:** Yes, I know. You summed up before—without any consultation then, much less now.

**Mr. Chairman:** Is the minister not going to appear then on Wednesday?

**Mr. Boddington:** I believe his intentions were to appear with Dr. Lynes on the day that he was to sum up. I could certainly ask him if the committee wants to—

**Mr. Kennedy:** I wonder if Dr. Anderson and Dr. Durost could come on Wednesday in lieu of the minister.

**Mr. Chairman:** And Dr. Lynes. The minister wants to appear with Dr. Lynes.

**Mr. Boddington:** That's my understanding.  
[5:30]

**Mr. Chairman:** Okay. Would that be all right, Dr. Anderson, Wednesday? And Dr. Durost, Wednesday? Perhaps we could have you on first, in view of the fact that you have been inconvenienced today, which would be one o'clock. I don't see any other alternative really. One o'clock Wednesday, if that would be satisfactory. Thank you very much, gentlemen. I am sorry for the inconvenience.

Now, then, Mrs. Jones, thank you for coming and perhaps some of the members have questions.

**Mr. Duksza:** Mrs. Jones, what effect will the closing of Lakeshore have on provision of services in Peel county?

**Mrs. Jones:** Well, I guess the concern that the Peel Social Planning Council has expressed is that we don't exactly know what effects the closure is going to have. There is a local planning committee for the Peel area, I guess part of Dr. Lynes' overall committee, that is looking at the provision of outpatient services from Lakeshore that will be relocated and what the effects will be on Peel.

The Peel District Health Council has investigated mental health services generally prior to any of this being announced. They were requested by the ministry to do a complete inventory of mental health services in Peel and to make recommendations to the ministry about possible developments in the mental health field and they submitted four



specific proposals to the ministry and received approval in principle for one, which is the North Peel Aftercare Program that was mentioned by Mrs. Best. We at present have such a program operating in the south.

**Mr. Duksza:** What are the three additions?

**Mrs. Jones:** Crisis Intervention Centre, operating out of Mississauga Hospital Emergency Department, Community Mental Health Centre in the Mississauga area, and the North Peel Halfway House were the other three that were rejected.

**Mr. Duksza:** Are those in response to the present crisis, or have you been trying them for some time?

**Mrs. Jones:** They were developed in response to a specific request from the ministry, but prior to the announcement of the closure. The ministry said, "What mental health services would you like to see developed in Peel," and the district health council asked the two hospitals to come up with two specific proposals each and these were what they were.

**Mr. Duksza:** If those four proposals were implemented in full, does that cover the lacuna produced by the closing of Lakeshore, or not, in your opinion?

**Mrs. Jones:** It doesn't appear to. There are several services currently operating out of Lakeshore that are not duplicated in any way in Peel, such as the alcohol program, the retardation program, the psychogeriatrics, the child and adolescent unit, the crisis emergency psychiatric care, and the high security unit, where protection is required either for the patient or for the people caring for him. We have no facilities for any of those types of programs at present in Peel. We have been assured by the minister that the outpatient programs will not be discontinued but will be relocated, but at the present time they are not offered within the community of Peel.

**Mr. Duksza:** But the problems that you mentioned, only some of them are outpatients. The crisis centre and the unit dealing with potentially dangerous people are not exactly an outpatient service.

**Mrs. Jones:** No. There are both inpatient and outpatient services that are lacking in Peel.

**Mr. Duksza:** Then your own proposals to the minister now will have to be seriously modified and augmented because of the closure of Lakeshore?

**Mrs. Jones:** I would think so. There is currently a study under way in Peel about

health services in general. You may or may not be aware that there is a new hospital planned for the Mississauga area and that a committee of the district health council and the staff are looking at services to be placed in the new hospital and looking at that in the context of the entire needs and resources of the community. That is in progress at the present time.

**Mr. Duksza:** Obviously you must be aware of Dr. Mech's opinion, the past director of the Peel Memorial Hospital psychiatric unit, that it will have a very deleterious effect in dealing with the "unmanageable patient." What will happen to that group if Lakeshore is closed?

**Mrs. Jones:** Apparently they will be taken to Queen Street.

**Mr. Duksza:** What will happen to the contact these people have in the community? Do you think it will affect them? If they now go to a much better hospital, although Lakeshore is not exactly closed, do you think they will be affected?

**Mrs. Jones:** It will depend, I guess, on how the hospital deals with these people. It would be my opinion that usually these people aren't long-term cases; they require fairly short-term care of that high security nature. It is possible that they might be transferred back to the community general hospital following some stabilization.

**Mr. Duksza:** In your opinion is it always necessary to have a psychiatric unit in a psychiatric hospital which acts as a back-up facility for a psychiatric unit in a general hospital?

**Mrs. Jones:** I suppose where it doesn't really matter, as long as it has the service that the person needs at that time.

**Mr. Duksza:** Mr. Fisher brought out the point that maybe we will finally be able to deal with all problems within the community. That incidentally is quite against what most experts have been saying in community psychiatry recently; that in fact they have probably bottomed out. You represent a very specific group which on a primary level deals directly with many patients. In your opinion is it possible for us to deal with all the problems in the community?

**Mrs. Jones:** Let me clarify what I'm representing. It is the social planning council, which is a planning body for social welfare services in the community.

**Mr. Duksza:** I call that the very primary level.

**Mrs. Jones:** We don't deal specifically

with clients or specifically with mental health clients.

**Mr. Duksza:** I know you don't treat. But you deal with the problems of living. Some of them are in fact psychiatric, and you are responsible for planning, which is much more than the ministry does at the moment, it seems. Give me your opinion on that point.

**Mrs. Jones:** I think Peel is very hard-pressed to deal with social welfare problems in general. A fast growth rate, the creation of totally new communities lacking in services, the lack of a community identity, I think are several factors in Peel that make our ability to deal with social and welfare and health problems in the community somewhat less than in older, more established communities.

**Mr. Duksza:** I have asked you a number of questions. I do get the sense of disquiet you have about the lack of planning and the potential problems that could occur if Lakeshore is closed, and the fact that some of the basic units which dealt with the more disturbed patients will either be gone or will have to be moved to Queen Street. Do you want to add any other concerns you have about the provision, from your view, of mental health services in Peel county?

**Mrs. Jones:** We felt that in both the actual decision to close the hospital as well as Dr. Lynes' planning committee, the community has not been involved to any great extent. The planning committee is composed of health professionals. There is one representative from the health unit and one from our local mental health Peel group. But other than that there is no community, no social service, no social planning, no consumer input into this planning committee. And there have been no communications from the committee to the community about what the committee is considering or requesting input on. There has been nothing.

We do have some concerns about how this whole process is being carried on in the community, especially in light of the fact that the district health council is currently studying health needs and is planning to present a very specific proposal on total health needs within the next year.

**Mr. Chairman:** Thank you very much, Mrs. Jones. You have been a very good witness and we are sorry for the inconvenience of having you return. Mrs. Latimer? Mr. Ramsay?

**Mr. Ramsay:** Mrs. Latimer, you are listed here as the director of nursing at Lakeshore

Psychiatric Hospital. Is it not correct that you have been transferred to Queen Street?

**Mrs. Latimer:** No, I worked at Lakeshore for 15 years prior to my transfer on April 2.

**Mr. Ramsay:** You've been there since April 2? What were your feelings, Mrs. Latimer, about the closing of Lakeshore?

**Mrs. Latimer:** They were very mixed actually. I'd like to say this is quite personal. I hated to leave the hospital that I had been part of for so long and where I had worked with such an innovative group of people. Also, for four years, I had worked with the nursing department and it was one of the best in the province, I think. I would stake my life on it. I have gone to a hospital that hasn't had a director and is somewhat lacking in direction in nursing. But, on the whole, from the patient's point of view, I think it's the best thing that could have happened.

**Mr. Ramsay:** In what respect, Mrs. Latimer?

**Mrs. Latimer:** I've only been there one month and I look at the patients on the wards who have already moved there, particularly the psychogeriatrics. They have so much space and there is so much available that we could never match at Lakeshore. I mean we couldn't even put dryers in to help them do their washing because we didn't have hydro.

**Mr. Ramsay:** Mrs. Latimer, I'd just like to get one point clear in my own mind. What is your capacity now at Queen Street?

**Mrs. Latimer:** I'm director of nursing.

**Mr. Ramsay:** Director of nursing at Queen Street. What about the rest of the nursing staff transferred to Queen Street from Lakeshore. Do they feel the same way you do?

**Mrs. Latimer:** None of the nursing management group at Lakeshore has been transferred to Queen Street. They are really only a bargaining unit at this time. A lot of the nursing management group has been left in outpatient positions at this time and we really don't know why. The nurses who have transferred are in the bargaining group. There is one head nurse and they all have adjusted well and feel very good about it. I think there is always an orientation problem and they are working through it. On the whole, they are just as happy.

**Mr. Ramsay:** I think I may have interrupted you and I apologize. But you were starting to relate some of the advantages that Queen Street might have over Lakeshore. Could you elaborate on that?



**Mrs. Latimer:** It's like comparing the Royal York Hotel with the YMCA. There are bathrooms in the rooms. It's just remarkable that you have a six-bedroom unit and enough toilets and washbasins to be able to wash these people individually. For example, for the psychogeriatrics there is suction piped through the wall which is just very good, in an old people's ward, as you know, because of some of the physical problems. So I think it's really kind of odious to make comparisons because the facilities are so superior at Queen Street in every way.

**Mr. Ramsay:** You are speaking with great respect of the standard of nursing at Lakeshore. Do you feel that that standard is just as high at Queen Street?

**Mrs. Latimer:** I really don't know enough at this time. I'm sure that it is.

**Mr. Ramsay:** I think this question has probably been answered by Mr. Fisher but I'd like to hear your comments, if you don't mind. He felt quite confident that the in-patients at Lakeshore can be easily accommodated at Queen Street. Do you feel the same way?

**Mrs. Latimer:** Yes, I do. I have been around to all of the services and met most of the nurses, as much as possible, who have been on days and afternoons. The actual space resources are quite remarkable. Then, the community centre, in which there are the kinds of things that really simulate living activities in the community, is just great. I think that if every psychiatric hospital in the province had that, we really could work a lot harder at getting people adjusted to community living. So there's nothing to compare, really.

**Mr. Ramsay:** Mr. Chairman, I would advise that I asked at the close of the meeting on Wednesday for the opportunity to go to the two hospitals. In fact, I suggested that it might be beneficial for all members of this committee who have not gone there to do so. I'd just like to make it known to you that I did go out to Lakeshore on Thursday. I am going with Mr. Conway and a few others to Queen Street tomorrow. I would like to recommend again that as many members of this committee as possible, who haven't already been to the two institutions, go out there.

**Mr. Chairman:** I had understood that but I gather that one, two or three members had already taken it upon themselves to go out there. I just wonder, in view of that, if perhaps any other members of the com-

mittee who wish to do so would go tomorrow when Mr. Ramsay and Mr. Conway are there? [5:45]

**Mr. Conway:** Regrettably, the steering committee did not meet for reasons that I am not aware of. One of the things we did encounter was the fact that a good number of people had been to one or the other of the facilities. I know I felt I did not want to tie people up by going back to Lakeshore when I felt I had had reasonable exposure there, but I did want to go to Queen Street. Given the fact that most members had been to one or the other, it was generally thought that perhaps individual arrangements could be made. But if that is not satisfactory, notwithstanding the fact that I think we have all had reasonable opportunity to acquaint ourselves with the physical plants of both institutions, then perhaps we can go as a committee. I do not think it is a particularly high priority for a lot of members who have been there, but if others feel differently—

**Mr. Duksza:** I do not personally feel obliged to go again, but I think it is a good point.

**Mr. Conway:** If the member for Parkdale wishes to treat us to perhaps a wide-ranging tour—

**Mr. Kennedy:** He can buy the lunch.

**Mr. Chairman:** I have been to both facilities and I would highly recommend it to members. As I understand it, there are two or three at least who have made arrangements to go at 12:30 tomorrow. If that fits for other members of the committee, perhaps the clerk could be in touch with them and they could hook on and go as a group.

**Mr. Duksza:** To Lakeshore or Queen Street, or are you going to both?

**Mr. Kennedy:** This was Queen Street at 12:30.

**Mr. Conway:** I think the New Democratic members have all been to one or both, am I not correct?

**Mr. Duksza:** Yes, but we went to talk to the administrator and to the medical director. I went through but it does not count; the other people did not go through and discuss with other people much more, generally. We have been to both a number of times, but that is different.

**Mr. Chairman:** Perhaps we can arrange for those who wish to go, to join with Mr. Ramsay and Mr. Conway tomorrow to visit Queen Street, and then if there are others who want to visit Lakeshore and who have not done so, perhaps we can arrange to do so at a later date.



**Mr. Belanger:** I was under the impression we were going to both places tomorrow.

**Mr. Chairman:** You are going to both from 12:30 until two?

**Mr. Conway:** It is my understanding that those of us who want to tour Queen Street will meet at Queen Street at or around 12:30. Others having the wish to go to Lakeshore will be at Lakeshore somewhat earlier—or after. I think I see Mr. Boddington nod that it is after. So it will be Queen Street and then Lakeshore.

I suppose if there is a desire on the part of committee members to do more than acquaint people with the physical plant and such, there is no reason—

**Mr. McClellan:** If members want to go on a guided tour with staff of the Ministry of Health, that is fine. That is not what we were talking about earlier in the committee. I will hope it goes back to the steering committee, rather than to hassle it out here. But that is not what we had in mind, I think, when the original suggestion was made.

**Mr. Dukszta:** Yes, I think there is a difference between a guided tour and just going to see the administrator and seeing it as a committee in much more detail.

**Mr. Chairman:** I was not involved.

**Mr. McClellan:** Mr. Lawlor unfortunately is ill and hopefully will be back with us shortly. I say “hopefully”; once he is back perhaps I can leave it with the steering committee to—

**Mr. Chairman:** I just want to say, Mr. McClellan, it is a matter with which I was not involved.

**Mr. McClellan:** I understand that.

**Mr. Chairman:** I just realized that some of the members were going on their own. Mr. Ramsay, perhaps we can leave it at that. The steering committee can take it up and we can get on with it here.

**Mr. Ramsay:** I would just make one comment about the visit. I was concerned that I would not have the opportunity, whether it be on a group of the whole committee or individually, to get out there before these sessions convened again today. I had hoped to visit both hospitals at the same time and there was not sufficient time to do so. So I was not trying to circumvent the group tour. I just wanted to have the opportunity to see the facilities and therefore be a little more knowledgeable at the committee meetings today.

I am sorry, Mrs. Latimer. I got off on a tangent and got everybody else off on it too. But I wanted to come back to a couple of

questions. There has been concern and justifiable concern about the well-being of the staff at Lakeshore, whether they will all be accommodated, whether they be nurses, maintenance staff or whatever the case may be, in other institutions. What portion of the nursing staff you headed up at Lakeshore will be transferred to Queen Street?

**Mrs. Latimer:** All of the nurses in the bargaining unit are going. In fact there will even be vacancies because some have left. We usually have a normal attrition in the summer. Even the nursing management group have got positions to use their expertise in the outpatient areas.

**Mr. Ramsay:** Just two more questions: I noted the press reports and the television coverage of the move by the inpatients from Lakeshore to Queen Street. There were charges at that time that this was going to seriously affect these people. Was that, indeed, a fact, and how did their families react after it was all over? How do they now feel about the move?

**Mrs. Latimer:** Well, I actually went up to the psychiatric ward last Tuesday. That was the last visit I made there because I was off for the rest of the week. I talked with a lot of them and I talked with the staff again, and I think you can check on it. They have all integrated pretty well. We actually had people who were under 65, but we have them in a medical-surgical component. Some of them have even been moved a little bit, just to put them in with people more in their own age group. There really seems to be no major problems; in fact, some of them are sleeping better because of single rooms and things like this.

The other patients who came from West North York, which you know was the other transfer, were accommodated to the three services—I think five went to southwest and two went to north and then two went to southeast. They are still all in, but there is discharge planning going on for two or three of them and the rest are longer term and will need longer hospitalization. They are all doing quite well.

**Mr. Ramsay:** I think there was a second part to my question, and that was the concern of the families, the relatives, about moving these people and would it be further for them to come and the new conditions and so on. How are the families reacting?

**Mrs. Latimer:** I think the relatives are probably the ones with whom we have to spend more time. This is probably a much more major problem for them than for the patients. I did talk to one relative of one

old man who was there and they were quite happy. I think once they come and adjust and see what is available, it is just a question of getting to know the place. They, too, have fears about orientation, how they are going to get there, and how to use the TTC to get to Queen Street as opposed to Lakeshore. Once they get comfortable, they are much better. I think we really will have to work with them more on that.

**Mr. Ramsay:** I have one more question, Mrs. Latimer, and it deals with something a bit more topical than the questions I have passed along to you to date. There have been a number of concerns expressed about the increased number of group homes in the Parkdale area. I was wondering how you see the closing of Lakeshore affecting the outpatients requiring group homes. Where do the Lakeshore patients live now?

**Mrs. Latimer:** Well, funnily enough, most of the long term patients we discharge, live in the Parkdale area anyway. We actually encroach on Queen Street's area because it is the only place we can locate group homes. In actual fact, we probably have up to 40 or 50 re-admissions a month from that area. They really belong to Queen Street, but they are our responsibility, a moral responsibility. This is mainly due to the zoning and the problems of locating group homes in our catchment areas.

**Mr. Duksza:** Mrs. Latimer, I was very pleased to hear how widely you praise Queen Street; it is music to my ears. It does not really change the fact, I suppose, that one is a perfectly modern facility and one is an older one. Would you not agree if Lakeshore was rebuilt in a modern style it would provide an equally modern facility as the Queen Street right now?

**Mrs. Latimer:** Gee, that is a loaded question, Mr. Duksza.

**Mr. Duksza:** Yes. Indeed, I was making it loaded.

**Mrs. Latimer:** Let's put it this way: I think, and this is personal, and I would really like you to take it this way, to me, and to many of our patients, Lakeshore is an asylum and it looks like one. I think we could rebuild it and we could certainly improve it, but it will never be a Homewood. My own personal opinion is we need a new facility with a new image and then people will stop thinking of the funny farm or the lunatic asylum and what not. I would have to say that is personal, and my fondest wish would be to have a really new facility in the west end of Toronto where I could work. But I know what is going on, we have in-

flation, we have cost factors, and maybe five years from now you will all sit together and reconsider that and give us one.

**Mr. Duksza:** Good point. You say that is your own feeling, both as a professional and as someone who has given some thought to the problems of health care. You think there, in fact, should be a rebuilding or a new facility in the west end which will abandon the feeling of its being an asylum?

**Mrs. Latimer:** That is my personal opinion, but I also think you have to look at the municipal level of politics; who is in power as mayor, who goes for rezoning, and who goes for multiple unit housing. That would certainly influence our demography, wouldn't it?

**Mr. Duksza:** The problem, I think, exists at the moment and I cannot but stress it again. In effect, the reaction in ward two, Parkdale, is such towards further group homes that it would be impossible and, I think, appropriately so, to build in one area any more to set up homes like that.

But let me just return to that point that you mentioned because, actually, that fits with the McKinsey recommendation that you either upgrade or rebuild a hospital which will be closer to where the patients live and it has to be modern and the old connotations of a lunatic asylum have to be abandoned. So, in that sense, I agree with you.

It's interesting; why would you say that you would be happier to have a rebuilt hospital in the west end? What would be your thinking on that point?

**Mrs. Latimer:** It's perhaps one's self-interest really. I like the west end, I would like to see it developed more in terms of mental health services. I thought there was a lot of relevant stuff said today. I think it's a new community with the city of Mississauga and the Peel regional concept. Really, instead of having a bunch of entrepreneurs, we have to spend a lot of time to have a well-co-ordinated, mental-health-care delivery system that covers the whole area and we have to work at it.

**Mr. Duksza:** Yes, I know. I agree entirely. Have you read the McKinsey report?

**Mrs. Latimer:** It was confidential for so long and then I skimmed through it one time through the courtesy of our administrator. Then it was distributed, but it never did get distributed through the hospitals.

**Mr. Duksza:** It's interesting, because even without your reading it in particular, you obviously reflect what is a prevalent orthodoxy amongst the health professionals that the delivery of health care should be in the



smaller places right in the community, but has to be more than a facility. No one will defend the old Lakeshore. I think that is what you were saying to me, at least, in terms of facility, in terms of physical plant. I've always been impressed by the service provided and you, also, said there is no difference in nursing care between the two, in effect.

**Mrs. Latimer:** I also, as a taxpayer, would question why you've got 300 empty beds at Queen Street and you're not doing anything about them.

**Mr. Duksza:** That's a good point. A few years back, as you know, there was a move among the professionals in the community to persuade our government not to build the two towers but, of course, the government insisted on building. In that sense, I don't know why we should suffer because they made the mistake of spending our money to such a degree. Should we fill the hospital merely to satisfy Mr. Timbrell that the beds should be occupied by someone? There are other facilities for it. I don't think the imperative of filling a mental hospital with patients is something which should govern us in terms of combining the two hospitals and creating this gigantic catchment area. What are your own feelings about the size of catchment areas and hospitals?

**Mrs. Latimer:** I'm glad you asked that. Having read Action for Mental Health and More for the Mind which, as you know, are the American and Canadian studies in this area in the 1960s, I certainly did not endorse large hospitals. But, one thing I was really gratified about when I went to Queen Street was the regional concept because, in actual fact, there are four mini-hospitals within a large one and I really do feel that patients' individual needs are met. There is a community feeling because of this kind of regional concept, and within the regional concept there's a functional concept which means that, again, individual needs of patients are looked at. So I feel rather positive about it, considering it's such a large hospital.

**Mr. Duksza:** Within the context of a large hospital, I suppose it's the only thing one can do; I was there when the break into units concept was created. Of course, one of the difficulties was that the ideal, according to the joint commission report, has always been that the small units should be in the community. But it was very difficult to break it up. You were quite right in what the joint commission has suggested, small hospitals directly in a community. Unfortunately, however, we seem to be reversing that trend by,

not only making hospitals into smaller units but, now, coalescing two hospitals. Soon, of course, they will add something from Owen Sound or wherever it is, knowing the particular new trend the minister is involving himself in, centralizing the delivery of psychiatric services. I hope it will never come to that.

**Mr. Chairman:** Mr. Conway, you have three minutes, according to that bell.

**Mr. Conway:** I apologize for being late for the first part of your testimony. Unfortunately, I had another meeting to attend. But you have been, I understand, at Queen Street for roughly one month?

**Mrs. Latimer:** Yes.

**Mr. Conway:** And you, I gather, have no real concerns about the capacity of that institution to deal with what we will direct to it with the changes at Lakeshore?

[6:00]

**Mrs. Latimer:** No, I feel very good about it, actually.

**Mr. Conway:** You're a front-line professional and that's what we're here to listen to. I suppose if I have one basic concern, it is something that Mr. Duksza mentioned and something that was touched on by a previous witness, that is, just as a lay person, a taxpayer and now a politician, I fear a little bit to think that it was a rational planning mechanism that built this Queen Street facility with so much excess capacity that it sat there for two or three years.

One wonders what on earth would ever have happened to it had McKinsey been accepted and another facility built in the west end. I have this image, which I am sure will be corrected tomorrow when I get there, of all kinds of incredibly empty space that can be reorganized at the whim of a minister and administrator, and it seems to be widely accepted by the professional staff. It makes me wonder how many other such facilities are in a similar position.

Maybe this inquiry is properly going to look at that general public hospital sector, to see how many other white elephants, in a sense, are extant in the land. I'm alarmed to hear what I've heard here today about what's been sitting over there for two or three years. It seems to be, if nothing else, a stinging condemnation of planning in the not-too-distant past.

**Mr. Duksza:** A stinging condemnation of non-planning in the past and non-planning now.

**Mr. Conway:** That's my observation. I have no reason to doubt what you said. I just hope



that it does have the capacity because, as I indicated to the administrator, I would be a little bit unhappy if two, three or four years from now, for whatever reason, we are presented with a proposal to go back, if the decision is continued to destroy the Lakeshore facility, with a request five years from now to build it at a cost not of \$25 million, \$50 million, \$55 million, or \$75 million for all the reasons that we have heard.

**Mrs. Latimer:** But that could happen, couldn't it, because of the demographic shifts, because of immigration and because of whatever might happen in our Metro area?

**Mr. Conway:** That is what we as so-called legislating policy-makers have got to be most concerned about.

**Mrs. Latimer:** You know more about that than I do.

**Mr. Conway:** You have no difficulty at all as a professional insofar as having been at Lakeshore and knowing the kinds of institutional requirements that are presently in place in this city to say to the general community that that entire shift can occur without any worry at all about the quality of care in terms of that Queen Street facility?

**Mrs. Latimer:** That's not quite accurate actually. Of course, I am concerned about the quality of care; that's my prime concern. If you have any major shift in any area, even within your own hospital, you have to look at the ripple effect that happens through your system. So possibly you will get more problems.

Lakeshore reorganized twice, I think, in the four years that I was there. Each time you have a rise in things like WCB's acting or instant. It's a natural trend that you can pick up. You anticipate some of these things. It will not be problem-free, I can assure you, but there will be problems that we'll be able to handle.

**Mr. Conway:** Thank you.

**Mr. Chairman:** Thank you very much, Mrs. Latimer. I should mention to Mr. McClellan that it appears the Treasurer wishes to appear in person to answer his questions. Unfortunately, he's out of the country until May 2.

**Mr. Dukszta:** Until 1981?

**Mr. Chairman:** Perhaps he's organizing a chorus line with Mrs. Thatcher. In any event, you could wait until his return, could you? Thank you.

The committee adjourned at 6 p.m.

## SPEAKERS IN THIS ISSUE

---

Belanger, J. A. (Prescott and Russell PC)  
Campbell, M. (St. George L)  
Conway, S. (Renfrew North L)  
Duksza, J. (Parkdale NDP)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Kennedy, R. D. (Mississauga South PC)  
McClellan, R. (Bellwoods NDP)  
Ramsay, R. H. (Sault Ste. Marie PC)  
Sweeney, J. (Kitchener-Wilmot L)  
Turner, J. (Peterborough PC)

**Witnesses:**

Best, Mrs. J., Community Resources Consultants  
Jones, Mrs. L., Peel Social Planning Council

**From Queen Street Mental Health Centre:**

Anderson, Dr. D., Director  
Fisher, M., Administrator

**From Lakeshore Psychiatric Hospital:**

Latimer, Mrs. S., Director of Nursing

**From the Ministry of Health:**

Boddington, G., Executive Officer, Minister's Office  
Surplis, Dr. D. W., Executive Assistant to the Minister



No. S-9

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Tuesday, May 1, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

---

TUESDAY, MAY 1, 1979

The committee met at 3:45 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

**Mr. Chairman:** I call the meeting to order. I would like the co-operation of the committee this afternoon in dealing with our agenda. I think we are going to be under continuing time constraints because we have six people from whom we have to hear, one of whom has to leave by four o'clock. Perhaps we could move along. With the concurrence of the committee, we'll take about 20 minutes with each witness, if that's agreeable; otherwise we are not going to complete things this afternoon.

**Mrs. Campbell,** you have a point with which you want to deal.

**Mrs. Campbell:** Yes. I crave the indulgence of this committee, Mr. Chairman. Yesterday in my discussions with Mr. Fisher I referred to a letter from the minister which I did not have available to me. The letter arose as the result of inquiries which I made of him in a letter dated January 22, which dealt with certain problems on Queen Street, Dunn Avenue and Beatty Avenue.

The minister's letter of February 28 is as follows: "Further to the recent investigation carried out by the psychiatric hospitals branch, my ministry was assured that our staff repeatedly visited residences in the King Street West area, and I was advised that none of the three Metro psychiatric facilities recommends patients ready to be discharged to take up residences in the above area. However, following discharge, their movements concerning residences are unfortunately beyond our control and in no way can we forbid them to select lodgings in this area. The matter of inspection and approval of such homes for residences and rental purposes rests with the municipalities."

I'll table this letter if you think it would be of assistance to the committee, Mr. Chairman.

**Mr. Chairman:** Thank you, Mrs. Campbell.

Dr. Wasylenki has to leave at four o'clock, so perhaps he could come forward at this time. Dr. Wasylenki is from the Clarke Institute. We are a little late getting started

today because question period went on a little longer than normal. For that we apologize, but hopefully we can have a productive 15 minutes.

Does anyone wish to ask Dr. Wasylenki questions? Mr. Lawlor.

**Mr. Lawlor:** The doctor doesn't care to make any initial opening statement at all. Is that right?

**Mr. Chairman:** Do you have an opening statement?

**Dr. Wasylenki:** I am sorry. I wasn't sure how to proceed here.

**Mr. Chairman:** Oh, I see. It's not necessary. You may, if you want to make one.

**Mr. Duksza:** Maybe we should just go on with the questions.

**Dr. Wasylenki:** I see, yes.

**Mr. Lawlor:** Go ahead then.

**Mr. Chairman:** Dr. Duksza.

**Mr. Duksza:** I have just a couple of questions. I think you are the chief of psychiatry in the Clarke Institute. Am I right?

**Dr. Wasylenki:** No, no, I am not the chief of anything.

**Mr. Duksza:** Oh, good.

**Dr. Wasylenki:** I am a staff psychiatrist at the Clarke Institute in the community psychiatry section.

**Mr. Duksza:** You are in the community psychiatry section. You must be dealing with a number of patients. Do you sometimes deal with Queen Street or Lakeshore or do your people, when attached to the Clarke Institute, remain with it?

**Dr. Wasylenki:** Clinically, I run an after-care service in the outpatient department at the Clarke Institute, so at times I have with dealings with both hospitals.

**Mr. Duksza:** What kind of relationship do you have with Lakeshore and with the Queen Street Mental Health Centre?

**Dr. Wasylenki:** It tends to be a clinical relationship almost exclusively, involving patient management most of the time.

**Mr. Duksza:** Yes. What happens to the people you deal with? If they need admission, are they admitted to the Clarke Institute

or are they admitted to the Lakeshore or Queen Street?

**Dr. Wasylenki:** They would primarily be readmitted to the Clarke.

**Mr. Duksza:** How many would not be admitted to the Clarke?

**Dr. Wasylenki:** It would be very rare unless there were some particularly specialized service to which I wanted access. I would think about approaching one of the OHs, usually Queen Street, because of the patient population I deal with and because of the particular revolving door program, for example, that operates there. That kind of specialized program is useful to me, working at the Clarke Institute.

**Mr. Duksza:** I know you are responsible for the program from the point of view of hospitals. Have you any suggestions as to how this community based program can be improved?

**Dr. Wasylenki:** Sorry, I didn't understand.

**Mr. Duksza:** How can this community based after-care program for which you are responsible be improved? What would you want done?

**Dr. Wasylenki:** To me, running a good after-care program is really a function of the ability you have to maintain patients outside of institutions, so all the elements of what I would regard as an effective community support system become crucial. For myself, I find home care is probably the single most important resource in determining whether my program is successful in an ongoing way. A group such as Community Occupational Therapy Associates, which provides home visiting and home monitoring of patients, is very valuable. The concept of chronic home care, as it's developing in this province, would be to me extremely useful in psychiatric after care. The difficulties I have are around the issue of ongoing home-care involvement, because many of the agencies that provide home care for many chronic patients find themselves unable to continue when the short-term goal is unclear. For me, the single most valuable resource and the one I would like to see expanded is really an alternative to institutional care, because often my contacts with patients break down and I end up having to readmit people because there just isn't enough community support available.

**Mr. Duksza:** How much home care is available? Maybe you could tell the committee in terms of percentages. I know when people come to ask me to facilitate getting home care, it's very time limited. The way

we pay for it is very time limited. Did you find that too?

**Dr. Wasylenki:** Yes, this is the difficulty I have, because of the way home care is funded. As you say, because of the way it's organized in Ontario it really can't provide ongoing involvement with the chronic psychiatric patient. I believe the government has thought about proceeding in that direction and I would certainly support them.

**Mr. Duksza:** Yes.

**Dr. Wasylenki:** The other home-care resource I utilize are public health nurses. Again, I find they can be very effective insofar as they avail themselves of some psychiatric consultation from my end so as to improve their skills a little bit in this area. In some ways, I find them more valuable as a resource.

**Mr. Duksza:** What would be the percentage of your patients for which you manage to get long-term home care?

**Dr. Wasylenki:** By hook or by crook, it's fairly high. It would be in the range of, I suppose, 60 or 70 per cent at any one time. It means moving around the system a little bit and encouraging people to think in terms of short-term goals and really wanting to think in terms of long-term involvement.

**Mr. Duksza:** There's been a discussion, and I and other people have asked the minister to move towards home care as an alternative for institution-based services. Unless that's provided, it's really very difficult to talk of moving into the community-based alternative psychiatric services. Am I right?

**Dr. Wasylenki:** I agree with that. I think if the intention is to close this hospital and to replace it somehow by a co-ordinated system of community care, then one of the very important elements in that system would need to be chronic home care.

**Mr. Duksza:** How easily could that be implemented on an immediate basis?

**Dr. Wasylenki:** I think it's relatively easy to implement and it only awaits funding.

**Mr. Duksza:** In your experience, how much would it be? How much do we need?

**Dr. Wasylenki:** I think we need it very badly.

**Mr. Duksza:** How much money would be necessary, what kind of staffing, what kind of programs are necessary to be able to implement it?

**Dr. Wasylenki:** I wouldn't be able to describe it in that detail.

**Mr. Duksza:** It's fairly extensive. How much staff would be needed? You say you



manage by hook or by crook to get some kind of home care for 60 per cent of your patients. There are another 40 per cent who could benefit. If there was some care you would save them travelling and otherwise coming to hospital.

**Dr. Wasylenki:** Sure, and I would much prefer to have them connected with a home-care program, certainly, than to have them institutionalized anywhere.

**Mr. Duksza:** A program like this would have to be fairly extensive before we can, in effect, talk of not using a bed but only providing home care. Am I not right?

**Dr. Wasylenki:** Yes, I think that would be important.

**Mr. Duksza:** Are we talking about the long term, many years for the development of the program?

**Dr. Wasylenki:** I wouldn't say so, because groups like Community Occupational Therapy Associates and the whole public health system are oriented towards moving into this field fairly immediately. Again, as I say, they only await the go ahead on funding. I don't see it as a problem that should take years to resolve, no.

**Mr. Duksza:** It is a question of funding then, but also an alternative approach by the people who make the decisions.

**Dr. Wasylenki:** It is the adoption of an alternative approach.

**Mr. Duksza:** How does it affect the provincial psychiatric hospitals, in your opinion?

**Dr. Wasylenki:** I don't know. I can only really speak from my experience at the Clarke Institute, where as I say, I use these services very extensively.

**Mr. Duksza:** Am I correct in saying if there was a fully developed psychiatric home-care program, we could probably save some money in terms of delivery of psychiatric services and may even have to have fewer beds?

**Dr. Wasylenki:** That would certainly be my opinion, and we would be rendering, I believe, a much preferable form of treatment.

**Mr. Duksza:** Thank you.

**Mr. Lawlor:** I will try to be brief and to the point. I was going to make a personal statement, but I won't. I don't know whether back pains are psychiatric in nature or not but sometimes I suspect they may be.

Have you read the McKinsey report?

**Dr. Wasylenki:** Not all of it, no.

**Mr. Lawlor:** What you did read, do you agree with?

**Dr. Wasylenki:** I have some reservations about it. I believe that what I am familiar with is a good description of the system as it exists. I have a belief of my own, however, that we could have a much better system. I believe one of the results of more of a community based orientation would be a need for fewer psychiatric beds.

I come from Saskatchewan where, as the McKinsey report points out, the ratio of beds per thousand of population is now down to 0.7. I am familiar with areas in that province—for example, the Yorkton catchment area—where the ratio is as low as 0.4. I understand clearly how that is achieved in that province. It is achieved by a substantial real commitment to community mental health and the developments of very real alternatives to institutional care. So I guess the comment I would address to the McKinsey report is, perhaps, that it is a little too descriptive with not enough prescription.

[4:00]

**Mr. Lawlor:** On the other hand, if the ministry and this particular province is not committed to a quite distinctive and different philosophy with respect to mental health care, and is unwilling to provide the funds necessary in that direction, then what do you say about the McKinsey report?

**Dr. Wasylenki:** Then the McKinsey report exists as an accurate description, in my opinion, of what we have.

**Mr. Lawlor:** May I just refer to page 48 of the McKinsey report? It's a summary of the situation:

"To summarize, a matching of the needs of patients with the characteristics of the public psychiatric hospitals suggests that the hospitals are well aligned to meet the treatment needs of the patients they currently serve. More broadly, this same analysis suggests the overall psychiatric care system in greater Toronto is well aligned. Were the slate somehow to be wiped clean, and a new system developed, we would propose care capabilities much like PPHs and psychiatric units and would assign patients roles much as they are now carried out."

Have you any comment to make on that summarization?

**Dr. Wasylenki:** Given a particular philosophy of treatment, I suppose that would be an accurate description. What I'm suggesting is that if it's the intention of the ministry in this situation to move towards a slightly different philosophy of treatment, then it's possible that I would be in sympathy with that and would suspect that if

it were to be implemented effectively, we probably could get by with a lower bed ratio than we presently have.

However, that would be a very significant undertaking, and it's not clear to me that the process of the development of alternatives, as it's been undertaken thus far, is really going to result in that.

**Mr. Lawlor:** Yes, very good. You've got a different approach and, I would take it, you have no particular reason to think that the ministry is at all fours with you and your thinking processes at this time in history.

**Dr. Wasylenko:** My only concern, as I say, is around the planning processes as I perceive it. It doesn't appear to me to be sufficiently systematic in terms of developing what most people would recognize as alternatives to a facility like Lakeshore.

**Mr. Lawlor:** I only have a couple of other questions.

To your knowledge, has the Clarke Institute itself been cut back in its psychiatric care? Are you suffering any ministry strictures, or constrictures?

**Dr. Wasylenko:** I'm not high enough up in the hierarchy to really comment usefully on that.

**Mr. Lawlor:** You do send patients—more difficult patients, but patients which are not suited to the purposes of your particular hospital—to Lakeshore, and have done so? You would send patients in that more critical condition to a place like Lakeshore rather than to a public hospital?

**Dr. Wasylenko:** If there are specific programs that address themselves to the needs of those patients that don't exist in my hospital then I would do that. But my experience, as I was saying, is that inevitably it is because there is a breakdown in the community support I attempt to provide for these patients that I end up having to rehospitalize them. The reason I would choose Lakeshore or Queen Street over Clarke Institute would really be a function, again, of the fact that there may be specialized programs in those hospitals that we don't have at the Clarke Institute.

**Mr. Lawlor:** Would it have anything to do with the seriousness of the condition of the patient?

**Dr. Wasylenko:** It tends to be more of a function, I would say—primarily a function of a need for dealing with the phenomenon of multiple readmissions. The program I use the most is the revolving door program at Queen Street now. Whether that's really the seriousness of the condition, it tends to be

more a kind of social breakdown that I perceive as having occurred in the patient. So I'm looking for a specific program that addresses itself to that issue.

**Mr. Chairman:** Dr. Wasylenko has to leave at four, but I have Mr. Kennedy, Mr. Jones and Mr. Conway. Perhaps we could move it along. Mr. Kennedy.

**Mr. Kennedy:** I just have one question and then I'll pass to Mr. Jones.

What does Clarke do that the other two institutions don't do—the other two facilities, Queen Street and Lakeshore? I think it was partially answered in an earlier question, Dr. Wasylenko. Could you comment on that?

**Dr. Wasylenko:** Well, that's an extremely complicated question now. All of these centres provide a degree of service, of research, and of education, and within each of those three areas there are, of course, differences from centre to centre. If we look at just the service area, there are programs at the Clarke Institute that don't exist at Queen Street and may or may not exist at Lakeshore.

For example, there's a fairly specialized gender identity program at the Clarke Institute which doesn't exist at the other two hospitals. On the other hand, up until recently there hasn't been a behaviour therapy program at the Clarke Institute but one does exist at Lakeshore. So in the service area there are a number of specialized programs in these hospitals that may or may not be duplicated.

**Mr. Kennedy:** They complement each other. Would that be correct in layman's terminology?

**Dr. Wasylenko:** I would tend to see the Clarke Institute as what one might describe as a tertiary care facility—that is as a hospital that offers specialized care within a network ranging from a general hospital that might offer primary care, through an Ontario hospital that might be seen as more of a secondary-care facility. So the idea is that there is more expertise of certain types in a tertiary-care hospital like the Clarke Institute, more research orientation, and they attempt to develop more specialized skills and knowledge. Whether that in fact happens is another question, but I think that would be the way of conceptualizing how the Clarke fits into the system.

**Mr. Kennedy:** I see. Do you see this proposal to close Lakeshore as having an impact one way or the other on the Clarke Institute?

**Dr. Wasylenko:** Oh, I think it would have an impact.



**Mr. Kennedy:** And the big question is what kind of impact.

**Dr. Wasylenko:** Yes. Hopefully it would help all of us develop stronger community supports for psychiatric patients in Metro Toronto.

**Mr. Kennedy:** Thank you very much. I'll pass.

**Mr. Chairman:** Mr. Jones?

**Mr. Jones:** I'll be very brief.

Doctor, I represent a larger part of the west Toronto-Mississauga area. I'm very mindful of the area's growth and we have a lot of questions about this community-based program you have mentioned. One of them is on the dollars and cents that this committee is concerned with. We've heard a figure, various figures, but you've just mentioned how you felt, what height you were in the level of certain knowledge. Do you have any guess, though, from your comments on a community-based services—

On top of the present expenditures a figure of \$1.3 million has been mentioned, I believe, by ministry people and others in the committee. Does that strike you, if you're given a guess—or would you hazard a guess—as a realistic figure for the kind of work you understand has to take place in this community?

**Dr. Wasylenko:** You could do an awful lot with that much money towards really strengthening many community supports in the catchment area of Lakeshore hospital—if it were done systematically. As I said, the difficulty as it appears to be is that it's being done rather haphazardly.

My concern would not be whether it's enough money but whether the money is going to be administered effectively. In my opinion, it's very important, in constructing a network like this, that it be done systematically in a co-ordinated fashion, and my perception of the way that that particular amount of money is being apportioned is certainly at variance with that ideal.

**Mr. Jones:** Finally—and I don't know if this is a fair question or not—are you prepared to venture an opinion on whether you agree with the closure of the Lakeshore hospital?

**Dr. Wasylenko:** It would be entirely contingent, as I said at the beginning, on the degree to which there's a clear commitment to an organized network of community alternatives.

**Mr. Conway:** Just one question that deals with the points raised by the two members from Mississauga. You've indicated, as I

understand it, that so long as there is seen to be a systematic approach to community-based mental health services for the catchment area, you have no difficulty, both as a citizen and a psychiatrist, with the phasing out of Lakeshore. You feel that it would not take a great deal of time; that, indeed, figures in the order of \$1.3 million represent roughly in your mind the kinds of dollars required; and that the time period involved to put in place the sort of systematic, community-based mental health services is not particularly long. Do I understand you to suggest that that could be done in the period of a year or two?

**Dr. Wasylenko:** Yes, I would be comfortable with that sort of time frame. As I said, my chief concern with the process as I see it unfolding now is as to whether it is in any way leading in a kind of systematic direction.

**Mr. Conway:** Could you just finally give us—and perhaps you did in your earlier responses which regrettably I missed in some measure—what would the key points be briefly in the building of that systematic approach?

**Dr. Wasylenko:** I think I can certainly comment on what I would see as the crucial building blocks in such a network. I think the crucial medical therapeutic resource is a partial hospitalization program with a strong home-care attachment. That's a facility where people can go to spend the day, part of the day, evening, night, which combines the benefits of inpatient hospitalization and at the same time mitigates the difficulties of institutional care. So a day hospital or a day therapy facility with a strong home-care component would be the key medical therapeutic resource.

**Mr. Conway:** Could you be more specific? Would that be centred at Queen Street?

**Dr. Wasylenko:** In my experience, Queen Street has an excellent record in the development of these kinds of facilities. You may be familiar with some of them—the Community Inn, and in the northern catchment area, Dundas Day Centre. These types of facilities I see as important key medical therapeutic alternatives.

In addition to that, such a network would have to consist of, and this is most important, alternate housing facilities. I'm sure you've already discussed this difficulty. I think this is probably the major problem in developing real community psychiatry in Metro Toronto right now—the lack of creative, alternative housing facilities in the city. Those would include approved homes, commercial boarding



homes but, more importantly, real therapeutic domiciliary approaches to care.

The next important component would be a network of vocational resources, that is a whole spectrum from a sheltered workshop approach for people who are unable to move into the work force to training for re-entry.

The third important component would be social recreational facilities. Again, you may be familiar with the Bloor-Spadina Club, and this sort of resource where people learn socialization, life skills, this sort of thing.

Now all that needs to be, in my opinion, co-ordinated both in its development and in its ongoing management. I think that's another important issue that someone has to address at some level at some ministry, that is, someone who might be responsible for co-ordinating a network of this type. I would see those as the bare bones of a network that would provide real alternative care to psychiatric hospital.

**Mr. Conway:** That testimony is extremely helpful and I want to thank you for it.

**Mr. R. F. Johnston:** I'm glad you outlined that network. From my perspective it seems to me that's exactly the kind of thing that would be needed as well. It doesn't seem to me, though, the kind of thing that you'd bring in under pressure of closing a hospital first and then coming up with a committee that works out, "Well, what are we going to do now with the outpatients?" I think that's what you were saying prior to this, isn't it?

**Dr. Wasylenki:** Without getting too much into time frames, the point I was trying to make was that in my opinion this kind of systematic planning should at least go along with planning to close a major facility like this.

**Mr. R. F. Johnston:** Right. Prior to it, hopefully?

**Dr. Wasylenki:** In the best of all possible worlds.

**Mr. R. F. Johnston:** Yes, okay. Like the time it seemed to me to put something like that into effect, both the planning and then the installation, would be more that the one year you were suggesting. Initially it would be two to five, wouldn't it?

**Dr. Wasylenki:** Well, you see, many of the components that I've described do already exist. From my point of view, the central task is really the task of co-ordination so it might be a matter of expanding many facilities which already exist and co-ordinating their activities better. That's why I'm a little bit loath to talk really seriously about time frames.

**Mr. R. F. Johnston:** One of the concerns I raised yesterday with the administrator of Lakeshore was the fact that there seemed to me to be an inconsistency in the approach and a reason not to believe that there was any commitment on the part of the ministry to doing what you're suggesting. Whitby is being rebuilt according to the specifications of McKinsey and, therefore, is obviously a commitment to that view of the world, and yet Lakeshore is being closed.

[4:15]

One of the things I forgot to raise was that he raised the example of Whitby's catchment area, including Scarborough, where there was a great number of programs available through general hospitals that were helping keep patient load down. I'm sure you're aware of those.

My question then, again on the further inconsistency, is: Why build up Whitby along McKinsey's lines when it includes one of these areas which supposedly is maintaining people in the community better, and get rid of Lakeshore, which isn't? Would you agree that that is inconsistent?

**Dr. Wasylenki:** It appears to be

**Mr. R. F. Johnston:** And I would suggest it doesn't include planning of the nature you're talking about on a consistent Metro-wide base as well. You would need this, because all four institutions to this point have interacted.

I just wanted to question for a minute your figures on the Saskatchewan thing. I think it's a little dangerous, from my perspective, to compare a demographic area like Saskatchewan with Toronto.

**Mr. Conway:** To say nothing of its confused political picture.

**Mr. R. F. Johnston:** I was just going to say that if there were fewer people in psychiatric institutions there it would only make sense, because of the millenium. There has been a change!

**Mr. Conway:** They're all in the Legislature.

**Mr. R. F. Johnston:** I would say there's no difference between Ontario and Saskatchewan—and I've only been here two weeks.

**Mr. Conway:** This place started out as an asylum, I would think.

**Mr. Chairman:** Order.

**Mr. R. F. Johnston:** At any rate, from the ministry figures given to us the beds per thousand ratio in Saskatchewan is 0.71, Ontario as a whole is 0.65, and Toronto with Lakeshore would be 0.39 beds per thousand,

which would be lower. Does that jibe with what you were saying? It doesn't jibe, it seems to me, with what you were saying.

**Dr. Wasylenki:** No, I was responding to figures in the McKinsey report. I think it's pretty difficult to think seriously about getting much below 0.5 per thousand.

**Mr. R. F. Johnston:** My next question was basically on that. When you're talking about this network, which you indicated — and that is my predisposition—to having an inpatient base to it some place—doesn't it make sense to have that, or—how do I get you to say it instead of me saying it?

I'm concerned about an institution the size of Queen Street in comparison with something like having a smaller institution in Lakeshore, say something in the neighbourhood of 200 to 300 beds or whatever, but fewer than 600 beds, and more in the community it is serving, as part of that network, for the growth of Mississauga. Would you see that as a more positive direction—to implementing the network you're talking about—to have smaller inpatient institutions dealing with a larger organized network by logical area?

**Dr. Wasylenki:** I think that ideally one would want to have many fewer beds than even 200 or 300 in the kind of facility you're describing, which would fit the model of the so-called community mental health centre. And it's again my view that if the closure of a large hospital like this would result in the development of this kind of facility, that would be a move in the right direction.

**Mr. Chairman:** Thank you very much, doctor; we hope we haven't kept you late.

**Dr. Roberts,** from the Royal Ottawa Hospital in Ottawa. Dr. Roberts has a time constraint as well. He must catch a plane back to Ottawa. So I would ask the members to use a little discretion in terms of time. Mr. Conway.

**Mr. Conway:** Mr. Chairman, just very briefly, I think the witnesses had the opportunity to hear the previous witness and some of the testimony—many of these questions become a little repetitious—I hope you'll bear with us. Your experience at the Royal Ottawa Hospital is of what kind? You're presently in what capacity?

**Dr. Roberts:** I am now the past chief. I was in charge of psychiatry for my first five years in Ottawa. I was responsible for the administration and organization of the service.

**Mr. Conway:** Have you had an opportunity to assess or in any way review the McKinsey report?

**Dr. Roberts:** Not in detail.

**Mr. Conway:** Are you familiar with its recommendations?

**Dr. Roberts:** The broad principles.

**Mr. Conway:** And how do those broad principles sit with you as a man of considerable experience in the field?

**Dr. Roberts:** Taking what I understand were the terms of reference, I think the report is reasonable. I think they were asked to do the wrong study. I think they were asked to study the replacement of the Lakeshore hospital, not to study the proper needs of Metropolitan Toronto. I can't disagree with what they say if I take those terms of reference, but I really have a fundamental disagreement with the terms of reference themselves.

**Mr. Conway:** What would have been more appropriate as terms of reference? Could you be a little more specific?

**Dr. Roberts:** I think a proper study of Metro Toronto's needs in terms of psychiatric services, including beds as one component. There has been an over-emphasis historically on the provision of hospitals and hospital beds in the whole health field. We know that. There are historical reasons for it, but I think we are in a period when our studies should be community-wide and comprehensive and not limited to how you plan to replace one piece of the network.

**Mr. Conway:** Just for those who may not be familiar with it, could you indicate whether or not such rationalization as being attempted here in Metro was such that would see the closure of Lakeshore and the movement of those beds and patients over to Queen Street? Has there been any like plan attempted in the Ottawa area in your time there?

**Dr. Roberts:** I live in the only part of Ontario with a metropolitan area that doesn't have a psychiatric hospital immediately available to us. We are served by a psychiatric hospital that's roughly 90 miles, an hour-and-one-half drive away and we are seriously handicapped by a lack of resources.

**Mr. Conway:** You mean the Brockville?

**Dr. Roberts:** But I don't think there has ever been a recommendation in Ottawa that the way to deal with that would be to provide a Brockville Hospital in Ottawa, but rather to provide Ottawa with the services



it needs with a comprehensive program such as was discussed by the last witness.

**Mr. Conway:** Are you suggesting then that if Metropolitan Ottawa-Hull, because I am sure that's part of your catchment area, one way or the other, has been able to survive without an OH in the metro area there, that perhaps west Toronto can as well?

**Dr. Roberts:** We have beds for immediate short-term care, and of course we have to provide practically all of that with our general hospital resources and with the Royal Ottawa, which is a community psychiatric hospital. We have a deficiency when we go to intermediate care; and we have, of course, a deficiency on long-term care. We feel those would be best met in general terms through community resources rather than a centralized facility. We are in process of adding specialized facilities to the Royal Ottawa and other hospitals, whether we talk of forensic or psychogeriatric, and so on, to meet those needs.

**Mr. Conway:** Who actually owns and operates the Royal Ottawa?

**Dr. Roberts:** The board of the Royal Ottawa Hospital. It's a former tuberculosis hospital which became a general hospital in one sense, and has psychiatric and rehabilitative medicine.

**Mr. Conway:** What percentage of your total operation falls into those latter two categories of psychiatric and rehabilitative medicine?

**Dr. Roberts:** I think rehabilitation is perhaps 15 or 20 per cent of the program. It's largely a psychiatric facility.

**Mr. Conway:** Yes. I take it, then, from what you have indicated, that you, as a physician, are strongly supportive of the deinstitutionalization trends that are current in the land.

**Dr. Roberts:** I am tempted to make some kind of a statement about this, but I don't think we can look at a single point in history. I think unless we try to see where we came from, something about how we got here and where we are and where we want to go, we tend to look at an isolated event and that makes it very hard to consider. I think the past 30 or 40 years have seen perhaps as rapid change in psychiatry as any other part of health, and yet we have been dominated by an historical system of psychiatric hospitals which were developed to meet the needs of another period, perhaps adequately. It's been very hard to bring about change in those systems, not just in Ontario but anywhere in the world, because they are large systems

and change comes very slowly and with difficulty.

If you go back to the 1950s the planning in this province and across Canada was for a total of over five beds per 1,000 for the mentally ill. You read the official health survey reports of that period, it was three and a half beds per 1,000 for straight mental hospitals, the others were special-purpose beds. It was only in the late 1950s and early 1960s with the introduction of some of the total milieu, some of the push from the community activities but also supported by newer medical treatments, that we began to see a reduction in bed use. The reduction in bed use started to appear and there were those who pointed out to this province at that time that we were perhaps already overbuilding in terms of mental hospitals. The last few mental hospitals that were built in fact are not functioning now really, they have been transferred to other purposes. I think it was apparent at that time that we were getting to be over-bedded and that the emphasis should be shifting to the community resource side.

But we have had great difficulty, because of the nature of the enlarged organization having funds moved from the operation of hospitals into the community side. I think that's where developments of recent years have been most encouraging, the fact that the government has been able to transfer some of the funds from the closure of psychiatric beds to the development of much-needed community resources. I am not sure if we are in favour of the shift, if we are creating a trend or if, in fact, we are trying to adapt ourselves to a trend that is taking place willy-nilly. A lot more people seek psychiatric help, but the number of days of care being provided in hospitals is very much reduced; if we keep up with that then we must shift our emphasis from providing large institutions to providing community services.

So I arrive at it out of a historical perspective rather than looking at it today and saying it's a good decision. I think it is a historical thing, that the time has come when Lakeshore and other psychiatric hospitals in this province are going to be closed; unless we are going to persist, in the face of what is happening in our society, in providing services that are no longer suited to its needs.

That's why I think we arrive at this plan now; if we could have mobilized our planning better, this might not have happened. I was looking back to recommendations made in the 1960s about the need to develop more comprehensive planning to emphasize com-



munity-support services. This is not new this year, this has been going on for years; but how do you bring about planning and change in large organizations—not just in government, in any large organization? So really, I think we are recognizing the situation and trying to adapt to it.

**Mr. Lawlor:** I take it from what you have thus far said that you disagree with the McKinsey report statement, and the whole of chapter three, Patient Needs Met by Psychiatric Hospitals? To give you perhaps a more specific reference they say: "Somewhat contrary to our initial expectations, this investigation convinced us that PPHs meet the needs of the types of patients they serve better than any feasible alternative, and thus we have concluded that they are an essential component of the greater Toronto psychiatric care system."

**Dr. Roberts:** I think there is a philosophical difference. It's not my philosophical position that providing care in institutions is the ideal way. I think there are enough beds available in Metropolitan Toronto to take care of those people who would be better served by the special service of a psychiatric hospital. It's a difference of position.

**Mr. Lawlor:** Yes, very considerable; at the opposite end of the spectrum. You therefore disagree with the corollary proposition that the kinds of needs serviced by a hospital such as you are connected with—a general hospital—that for the types of patients who avail themselves of that institution, because of the severity of their condition and the length of time which they must be hospitalized, a general hospital for quite a number of patients is not feasible or satisfactory.

**Dr. Roberts:** Many general hospitals today are not just acute-care facilities. They do provide intermediate, long-term chronic care. It's a matter of how one organizes the spectrum of services required in a community.

**Mr. Lawlor:** Have you ever done any costing with respect to keeping chronic patients, patients who would be there for a two-year period, say, at a general hospital over against a psychiatric facility?

**Dr. Roberts:** I have seen costing. If you organize your service in terms of the needs of people, one is not going to apply the same cost to an intermediate or long-term care patient as one applies in acute care. In a general hospital, if one looks at cardiac surgery, neurosurgery, psychiatry and many other things, there is a high variation in cost within those; and there is also a high variation in cost if you provide intermediate or long-term care in a general hospital. You

can't take the average figure and assume that will be the cost of caring for a particular patient.  
[4:30]

**Mr. Lawlor:** Doctor, in your perusal of the McKinsey report—I want to take a few moments to read certain paragraphs of the seventh chapter, on page three, pretty well the whole page, it says: "The psychiatric hospital system is especially vulnerable to budget cuts. For one thing, the system's constituencies are relatively small or have little political power. For example, greater Toronto PPHs serve only 10,000 people, many of whom are society's forgotten and unwanted individuals. In contrast, the other major institutional resource user in psychiatric care, the psychiatric units of general hospitals, serve about 60,000 people. In addition, general hospitals' boards of directors, quite naturally, fight to avoid budget cuts for their institutions, often mobilizing local politicians and public opinion. Thus, when budgets must be cut, it is often expedient for politicians and civil servants to take the money from the PPHs—institutions that are under their direct management control and far less visible to the public.

"Moreover, such cuts are usually portrayed as reductions in the size of the civil service, which technically they are. What is to be feared, of course, is that if this happens consistently greater Toronto's PPHs, which have improved over a number of years to a point where they compare very favourably with psychiatric hospitals in other jurisdictions, will be seriously compromised."

Have you considered that?

**Dr. Roberts:** I'm not sure I've considered it. I think it's a possible reaction, and a reaction that many of us have in psychiatry in that we have a difficult time in making our needs known and having them accepted. I don't think it's the same issue as whether or not one needs certain services. I think that's a danger in any health service that cannot gain wide acceptance from the public.

**Mr. Lawlor:** As a psychiatrist and as one aware of devious human motives operating, even unbeknownst to those who have them, is not the general tenor of this statement the fact they are more attackable, more vulnerable and more easily undercut?

**Dr. Roberts:** I guess I would say over the fence the grass is greener. In the community we often have the feeling they get better treatment than we get, so I guess it's a matter of how one views the scene.

**Mr. Lawlor:** The report goes on to say: "Psychiatric hospitals should be among the

last components of the health care system to suffer cuts in programs and services." That's underlined, by the way. "While expenditure priorities were not within the scope of this study, we feel compelled to comment on the basis of our general experience in health care and the knowledge of PPHs that we have acquired in carrying out this project. Most broadly, we believe that budget cuts in mental health services should be well down the list on any overall cost containment program in Ontario because other components of the province's health care system, such as general hospitals as a group, present far larger opportunities to reduce costs without impairing the availability and quality of patient care. Our view on where mental health should stand in cost-cutting priorities is shown graphically in exhibit 7-6.

"More specifically, if expenditures in mental health must be constrained, we believe that PPHs should be the last to suffer the cuts. The reasons are straightforward: psychiatric hospitals treat the most serious mental disorders and, because PPHs are the last resort in the psychiatric care system, their current and potential patients have little, if any, alternative source of care."

I just wanted to get that in the record, in case certain members, or any members of this committee, have overlooked the particular thoughts on this matter put forward by the government's own committee in this regard.

I want to talk about mental health with you, Dr. Roberts, in very broad terms. It seems to me, and I'd like to know if you agree or disagree with me, whatever the delivery system, the role of psychiatric hospitals as such is permanent, ongoing, abiding, and, damn it, expanding rather than contracting as you would wish it to be.

The whole of western thinking—I'm going to go back to Descartes—the human mind split at a particular point, between mind and body, between soul and mind, back about the 16th century. It's those radiating splits that have happened in all our personalities, where the heart can't speak to the head, with Pascal coming along afterwards saying it has a language that the head doesn't even know. That particular splitting, sometimes called schizophrenia, is a situation that is very abiding and ongoing. Look around this current society and you see it as a way in which human beings are racked, disgruntled, tortured—take a look at the clientele who come into our constituency office; meet our constituents—the degree of unhappiness in this society is not diminishing. The kind of un-

happiness we encounter every day of our lives, all around us, is of such a kind that it needs intensive, direct and continuous psychiatric care if there is to be any hope of success.

I think you will concede there is a hard core—I say it's increasing—of individuals who cannot be treated in any other setting or against other background than within the fairly close confines and with the kind of camaraderie they find within psychiatric hospitals. Huge hospitals break down that human touch, and thus the warmth of relationships, which is so vital to the healing process in this particular area.

To move in the opposite direction seems to me to be derogation of that. And what does it lead to? It leads to what the McKinsey report in another section says will be increased costs in terms of criminality, in terms of welfare recipients and in terms of the general dislocation in the society. When you reach conclusions about the functioning and location of mental hospitals, are all these considerations in your mind in the process of doing so?

Dr. Roberts: Mr. Chairman, could I make a few statements in reply? I could make it clear that, subject to about three provisos, I would be in favour of not rebuilding or continuing to operate the Lakeshore hospital. I think the provisos are quite clear. One would be that the funds that are saved from that should go into what some of us feel would be more advantageous mental health psychiatric services.

The second would be that the needs of the catchment area now served by Lakeshore should be met through appropriate planning. The third would be that the staff now involved, who obviously get satisfaction from and wish to continue to serve, would be given appropriate opportunities in the mental health field, either in the area or elsewhere.

I don't think anything that was said by me implied any belief that the funds for mental health should be reduced. I am well known as an advocate of greater funds for mental health needs. If we had the time to discuss some of the aspects of a preventive mental health program and the maintenance of mental health, I would be quite prepared to indulge in that exercise. I don't think that is really the topic of the subject here today.

A proposal has been made to close a facility. Some of us were asked what we thought about this. Some of us feel differently from other people, who are entitled to their views. There are, in our view, more appropriate ways to spend the capital and operating costs that would be involved in keeping



Lakeshore hospital open. We don't say that as an absolute. It is just our opinion based on our experience. There are other opinions and other experiences.

**Mr. Lawlor:** My primary concern, and the reason I made that lengthy statement, is about the ongoing need, which you did not address yourself to; and I can't say I really blame you for avoiding it. On the other hand, what you seem to me to be doing, with respect, is saying, as previous witnesses did, that you approach the whole issue from a distinct and separate point of view which you have no basis for believing the ministry gives adherence to or is seeking to advance; so you add your options.

Suppose "No" was said to you all along the line as to what your dream might be, would you support the retention of the Lakeshore hospital? If the schema you have in mind does not come into being, would you give that consideration?

**Dr. Roberts:** Mr. Chairman, I can't foretell the future. When the last psychiatric hospital was closed the ministry made available a considerable portion of funds for community services. I have no reason to expect they won't make available reasonable proportions of the funds saved from the closing of Lakeshore. I don't see any point in my speculating on what I might do if something or other did not come to pass.

**Mr. Lawlor:** On that particular point, we can only deal with the minister as to what disposition he intends to make.

**Mr. Chairman:** I should mention that Dr. Roberts' time constraint is even more critical than that of our first witness. The plane leaves at six o'clock. I would presume that Dr. Roberts would wish to leave here no later than 4:50.

**Dr. Roberts:** Right.

**Mr. Chairman:** With rush hour, and all, I would presume that would give you enough lead time.

**Mr. Jones:** In appreciation of those comments, Mr. Chairman, I'll be very brief. I would like you to clarify your position, Dr. Roberts. I understand you have been pre-eminent in this field for more than 20 years. We are talking about the closing of Lakeshore in the Metro area. I wonder what is your background as far as the Metro scene is concerned. Are you familiar personally with the Metro scene?

**Dr. Roberts:** Not for over 10 years now. I was familiar with it. I was executive director of the Clarke Institute in the first four years of its operation. At that time, I think I was familiar with the Metro scene.

**Mr. Jones:** Are you familiar with Lakeshore then?

**Dr. Roberts:** I knew Lakeshore at that time. I have not been there recently.

**Mr. Jones:** I appreciate your comments. I'd just like to clarify them. I believe Mr. Lawlor asked earlier about your thoughts on general hospital services and you replied that you have seen studies on the costing. Could you help me in just a general brief way? What restrictions or limitations do you see on general hospitals and their role in psychiatry?

**Dr. Roberts:** I've seen comprehensive hospital centres that I suppose are called general hospitals that include a great many services. I think it's a matter of how one wishes to organize these facilities; the degree of specialization you can allow, and the degree of autonomy you can allow for special needs, because certainly the needs of a patient in acute care are one thing but intermediate need and long-term need become different. The whole matter of whether you have ambulatory, self-care, industrial-type things going on in a general hospital is very complex.

I think we have a broad issue to face in the whole health field as to how far we generalize the general hospital and at what point we specialize. My impression would be that there is much more tendency today to talk in terms of the very highly developed tertiary care facilities, the lesser facilities and then the community facilities, at the same time recognizing that there are specialized programs for many kinds of illness, such as rehabilitation activities, that can better be conducted in special facilities.

It's a complex area. I would think that a general hospital, as we ordinarily know it, is not the best place for the care of a long-term patient; but I don't happen to think any institution is, except in very limited numbers. I don't know what the ultimate number would be and I think it really depends on the extent and nature of our community resources. One of the problems is we have not had, in this country particularly, a development community resources concurrent with the emptying of our mental hospitals, that is happening, say, in most parts of Britain; although even there, with their more highly developed community resources, they have this problem of how to really care for people in a community, but I think there is still a dedication to that being a better approach than to hospitalize or institutionalize.

**Mr. Jones:** In your just-finished dialogue with Mr. Lawlor, he was quoting to you from the McKinsey report. I know that some



of our NDP colleagues over there read it quite a great deal like a bible. I understand it was a consultant's report, and as you said there are opinions and opinions on this. You talked about your fight for funds and about the fact that you have been a leader in getting it out into the community. Is it your general perception, as a professional pre-eminent in this field, that there is resistance against this change? Is that, first off, anywhere evident in the professions, and more important, in the communities? Does it still seem to be an uphill fight?

[4:45]

**Dr. Roberts:** I am afraid I think it is. I think resistance to change is more deeply ingrained in all of us than we would like to admit. Intellectually or publicly. Change is discomfort. Change is precisely change; it arouses anxiety, there is a process to go through, and I think it is an uncomfortable thing.

Consciously and in conversation we say, "Please, let's have a change"; but I think we all resist it. I think the feelings about mental illness still run very deep. I think it is easy to say attitudes have changed and so on, but I am still surprised at the extent to which people will go to avoid seeking appropriate help or not being able to face up to the existence of mental illness. I think we have made progress, but I think we have quite a long way to go yet.

**Mr. Jones:** Thank you, doctor.

**Mr. Chairman:** Mr. Sweeney.

**Mr. Sweeney:** Doctor, you indicated Ottawa has no psychiatric hospital closer than Brockville.

**Dr. Roberts:** No provincial psychiatric hospital; no Ontario hospital.

**Mr. Sweeney:** Could you help me see the difference? I am sorry, I didn't understand that.

**Dr. Roberts:** I think size is different, financing is different, and organization is different.

**Mr. Sweeney:** Because you don't have that, has there been, in your judgement, a better development of a system for treating mentally ill patients?

**Dr. Roberts:** In my judgement, yes.

**Mr. Sweeney:** Do you have any evidence to indicate the needs of mentally ill patients are met less well in the Ottawa area than say in the Toronto area?

**Dr. Roberts:** I think in certain particular areas the answer has to be yes, because it is natural that in a centre with a much larger population certain specialized services will

develop more rapidly. We will look after things differently in some cases, without specialized services. I think one could take, for example, suicide, or the approach to rehabilitation through occupational therapy associates. This kind of thing I think has developed differently. I think the development of forensic services has been faster and more extensive in Metropolitan Toronto; and I think children's services are more advanced. If we take the overall generality, I think the approach to the care of the average person is as open, if not more so. I think we handle more through our general hospital units than would happen if there were a psychiatric hospital in Ottawa.

**Mr. Sweeney:** What would a patient receive at a psychiatric hospital that they would not receive in one of the psychiatric facilities in the general hospital in Ottawa?

**Dr. Roberts:** Well, certainly a facility the size of Brockville has a depth resource we don't have. It is much more developed in terms of industrial rehabilitation therapy than we could attempt, and they also have been able to develop an extensive psycho-geriatric service which we would like to see locally rather than 90 miles away. It imposes a real hardship on families and patients to have to travel that distance, but I think in the circumstances they have done a very effective piece of work.

**Mr. Sweeney:** In round figures, what percentage of mentally ill patients from the Ottawa area do in fact travel to Brockville, or are taken to Brockville?

**Dr. Roberts:** We think not more than five to 10 per cent of the admissions at one time. There is usually of the order of 300 in residence from Ottawa and its surrounding catchment area.

**Mr. Sweeney:** Are these patients who would tend to be hospitalized on a continuous basis, or are there some who live in the Brockville community?

**Dr. Roberts:** No, I am not counting those. They have their own immediate catchment area for which they provide complete care.

**Mr. Sweeney:** No, I am thinking of all the people from the Ottawa area.

**Dr. Roberts:** From Ottawa, there are people who require longer-term care in a facility designed for that, which we don't feel we should be doing. The very point was made about the cost: If we simply keep a long-term patient in an acute-treatment bed we are using costs and services unnecessarily. We don't have specially-designed, long-term facilities.

**Mr. Sweeney:** Would that be the main criterion for deciding a patient should go to Brockville rather than stay in the Ottawa area?

**Dr. Roberts:** Long term would be the main criterion. I might make one point, that for years we have been urging that the provisions for boarding out, home care and so on, supported at Ontario psychiatric hospitals should be available to other psychiatric resources. We cannot call on the use of those funds because we are not a provincial psychiatric hospital. These programs have been designed specifically for provincial psychiatric hospitals to get a patient into a stream so they can be returned to Ottawa or somewhere in the neighbourhood, with adequate support for their care. That's understandable, but it's a very good example of something we'd like to see extended to the community.

**Mr. Sweeney:** Your reference to a, better balanced I think was the term you used, overall system would make what you just described possible.

**Dr. Roberts:** That's right.

**Mr. Duksza:** Dr. Roberts, what is the size of your catchment area, if you operate under those terms?

**Dr. Roberts:** Our immediate catchment area is Ottawa-Carleton, and we also provide the backup service to six other counties. It's about 750,000 people.

**Mr. Duksza:** How many acute beds are there at the Royal Ottawa Hospital?

**Dr. Roberts:** At the present time we would have—

**Mr. Duksza:** Acute psychiatric beds of course.

**Dr. Roberts:** Yes; about 150.

**Mr. Duksza:** One hundred and fifty. Do any other hospitals have beds?

**Dr. Roberts:** Oh yes, we have a network. The Ottawa General Hospital has 45 or so; Civic Hospital has about the same; and Queensway-Carleton has 28 beds. We have a national defence medical centre, which is an unusual kind of service.

**Mr. Duksza:** How many acute psychiatric beds are there for the number of people?

**Dr. Roberts:** About 0.5 per thousand.

**Mr. Duksza:** It's about the same as here, isn't it?

**Dr. Roberts:** Yes, it's about the same as here.

**Mr. Duksza:** How many long-term beds have you got in the Royal Ottawa Hospital?

**Dr. Roberts:** Really none. We keep some long-term patients, but none of it has been designed for long-term care.

**Mr. Duksza:** Is your total bed count for psychiatry in the Royal Ottawa Hospital, 150?

**Dr. Roberts:** Yes. There are children's beds which I haven't mentioned because they are counted separately.

**Mr. Duksza:** I see. You say you transfer five to 10 per cent of your patients to Brockville. How many are there per year?

**Dr. Roberts:** I can't give you the figure. I know we have about 300 there at any one time, but it's several years since I've been involved in the process.

**Mr. Duksza:** I see. Is it 300 per year?

**Dr. Roberts:** No, it is 300 in residence at any one time from eastern Ontario.

**Mr. Duksza:** They are from eastern Ontario. That's approximately the same as Queen Street—

**Dr. Roberts:** It's about half a bed per thousand.

**Mr. Duksza:** That's about the same as what Queen Street Mental Health Centre provides for an area of the same size, and Lakeshore provides for a slightly larger area. In effect, you have acute beds in the general hospital and you have a backup facility for the second class citizen at Brockville. Am I not right?

**Dr. Roberts:** That's correct.

**Mr. Duksza:** I'm sorry, Dr. Roberts but I wasn't quite clear in following you. I thought you believed it would be possible to deliver all your services in the community, but now you tell me 300 beds in Brockville are yours?

**Dr. Roberts:** We have not been given any resources to design or develop comprehensive community services, except that which we can base—

**Mr. Duksza:** That is exactly what I was hoping you would say, Dr. Roberts, because I believe you are operating under the same conditions that Etobicoke is operating under with the Lakeshore hospital. Incidentally, we're not closing the hospital and moving towards the community, we are coalescing two hospitals into one. It is not quite the same as a movement towards community psychiatry generally, if I may say so.

**Mr. Conway:** Can we just be clear on one thing, because you have raised the matter? How many beds are there in total at the Brockville Psychiatric Hospital?

**Dr. Roberts:** I cannot answer. I would think it's about 500.



**Mr. Duksza:** The point is there are 300 beds as a backup facility, which is exactly the size of Lakeshore for its much bigger area, with 10 psychiatric units in Etobicoke and other places. Backup facility means they are unable to deal with certain patients who have to go to psychiatric units. We couldn't close Brockville because Dr. Roberts would not be able to deal with all those patients in the general hospital.

**Dr. Roberts:** That's not an agreed conclusion. We don't have an alternate facility. We don't have the resources to put them in boarding homes, we don't have the resources to provide community care. We would not ask for that facility to be transferred to Ottawa, but if we were given the funds we could provide care for most of those people right in the Ottawa community; and not in another psychiatric hospital.

**Mr. Duksza:** I entirely agree with you. I am like you, I believe psychiatric care should be provided in the community, but I'm not prepared to close a hospital and then develop it; because what do we do with those patients? I've worked with them and you've worked with them; you know you can't deal with them that easily. I'm not prepared to close the hospital and say we will deal with them immediately, because there is no money available. Anyway, to put it very bluntly, all they are doing is building another total institution, Dr. Roberts. The time probably has come for you to leave anyway.

**Mr. Chairman:** Dr. Roberts, we appreciate you coming down and sharing your views with the committee. We hope we haven't kept you too late for your appointment.

**Dr. Roberts:** Thank you, I appreciate the opportunity. I don't agree with the last conclusion.

**Mr. Chairman:** Thank you very much.

**Dr. Cooper:** Dr. Cooper is the chief of psychiatry at the York-Finch General Hospital.

**Dr. Cooper:** That is correct.

**Mr. Conway:** Mr. Chairman, I understand that hell hath no fury like two disputing and disagreeing psychiatrists.

**Dr. Cooper:** Not from what I saw.

**Mr. Sweeney:** The psychiatrist and the politician did okay; it's when you get them together that you get a problem.

**Mr. Conway:** Dr. Cooper, you are chief of psychiatry at York-Finch General Hospital. I had the opportunity to hear you address a public meeting in Port Credit. At that time, if my memory serves me correctly, you indi-

cated that your stand was one of staunch opposition to what was being attempted with respect to the closure of the Lakeshore Psychiatric Hospital. Could you comment in general terms about how you feel about the closure of Lakeshore as a practising psychiatrist in the catchment area, since I believe that York-Finch falls squarely in the middle of the catchment area? Could you particularly pay heed in your comments to the state of community-based mental health services as they relate to this proposed shutdown at Lakeshore and the transfer to Queen Street?

**Dr. Cooper:** York-Finch General Hospital has 17 beds. It serves a community of approximately 200,000. It's supposed to serve a community of 150,000 in wards 1, 3 and 5. It has a hard-core community of low-income families. There are 54,000 in the ward 3 area.

Lakeshore has always served as a backup facility and worked with us. I have found Lakeshore to be a well functioning hospital and an excellent community hospital. I find that the medical superintendent and the administrator there have been excellent people. As Mr. Lawlor said, they do speak with the heart.

They have all kinds of problems and all kinds of difficulties. They can tell us these difficulties; yet they realize there are people who must be hospitalized. They realize at times it may be difficult for them. The medical superintendent and the administrator at times have gone ahead and tried to work with their staff so that they can understand the difficulties of a psychiatric unit like York-Finch General Hospital.

We find communication is excellent. We find our patients who go there and then come back to us have a very good relationship with the hospital. We find that it really functions as a community hospital and not as a monolithic institution where there seems to be no heart and where people are just being pushed here or pushed there or whatever. In terms of psychiatric facilities or Ontario hospitals, when you begin to look at institutions I haven't seen one that functions as well as Lakeshore.

I cannot understand the imagination or the thinking to say in effect here is a hospital that everybody seems to like and to think is a good hospital, but let's get rid of it. Because we goofed in Queen Street and have an extra 300 beds, what we must do is fill up those beds. So let's destroy the relationship that we have with this hospital and which we've had with other hospitals



and let's try to make Queen Street work better.

To go into the history of Queen Street—and I'm only speaking for myself, as that's all I can do—up till March 1979 I could not understand how one would get a patient into Queen Street or how Queen Street functioned. I must say, with pressure and through the assistance of some ministry officials who recently have told me they weren't aware of how Queen Street functions, they have talked to them about the lack of co-operation and it now functions much better. They presently are taking in patients and providing a service. At the same time, I must remain kind of sceptical about what happens on September 1.

I am still trying to see what is the sense and the rationale behind making a decision to get rid of a functioning unit to try to improve the function of another hospital which really wasn't functioning, as far as I was concerned, in terms of our needs. This is my problem. As for looking into the future and saying what's going to happen when Lakeshore closes, I don't think anybody knows, and this is the bind we are all in.

[5:00]

People from the ministry are saying: "Let's meet and let's talk about the closing of Lakeshore and how it's going to affect the community. We have \$1.3 million here, which we're going to give away to all of Ontario. Give us your ideas. What would you like to see done with it?" I'm puzzled; I don't know what's going to happen. How can I give a plan when, in the first place, I can't even envisage the problems we're going to see? I don't think anyone honestly can, because no one can say what's going to be happening after September 1. This is the difficulty a number of psychiatrists are in. We're asked to give alternative plans. We're not consulted about a decision. We're not asked in terms of functioning.

The other big problem you're stuck with is, I cannot understand how a 600-bed institution functions better than a 300-bed institution, where there seems to be a complex organization already in the 300-bed institution and there is so much difficulty. Again, you're told by the ministry and people—and these are intelligent, well-motivated people—that things are going to get better. I don't mind if someone says to me: "Look, we have to save a buck. This is how we have to save a buck. The services aren't going to be as good as they were before, but we've got to save a buck." But to try to make us

think that we're saving a buck and doing better, or just as good, I can't buy that.

**Mr. Conway:** I take from what you have said that you, as a Toronto-area psychiatrist, would expect that the quality of mental health services in the Metro region, if this plan is proceeded with, will suffer.

**Dr. Cooper:** That's my fear. I can't say it will happen. Again, my point is that it has been functioning so well; they have been doing so well. It's really demoralizing to the staff and everybody—I'm talking about Lakeshore and everybody around—to find out that when you're doing a good job it's not appreciated. Then what happens? Somebody comes to you and says: "Okay, we're closing. We're going to move it over to Queen Street." There are all kinds of feelings, in terms of patients, in terms of staff and in terms of the mental health personnel who are working here. I think this is the major difficulty. There's a slight possibility it may be better, but that's just like saying to somebody: "Although you've got your house now, it's a good house and you're happy with it, I'll promise you another house, a better house, but I can't prove it to you right now. Trust me."

**Mr. Conway:** Do you believe the statement of excess capacity at Queen Street? Do you feel comfortable, from what you know from practising in this area, as to whether there is sufficient capacity at Queen Street to deal with the present and future requirements?

**Dr. Cooper:** I don't know. I know, up to about a couple of weeks ago, that I was being told there were no beds. I was referring people to Queen Street, and they were begging me, saying: "Please don't send them. Can you send them tomorrow? We haven't got beds." I found out, though, what it really was. There were certain beds in other units which were open, but the unit we contacted said there were no beds. Again, this is what I'm trying to say; this seems to be a very complex system.

**Mr. Conway:** How long have you been chief of psychiatry at York-Finch?

**Dr. Cooper:** Since January 1971.

**Mr. Conway:** So you've been there quite a while. Obviously, then, you have had the opportunity over those years to see the way in which general hospital budgets are developing and how your facility is funded.

**Dr. Cooper:** I'm speaking now as Jerry Cooper, a psychiatrist at York-Finch. The administrator of the hospital handles all those things, and a lot of the comments I have

been making may be very upsetting to him. I'm speaking for myself as a psychiatrist. I'm not speaking for the administrator or for the administration. As far as budgets and things like that go, we have very little power and very little to do with them.

**Mr. Conway:** Do you sense a squeeze at York-Finch? Do you, as chief of psychiatry, really feel that over the past eight years the financial resources available to you in your department have been less than you would have liked or expected?

**Dr. Cooper:** If you take a look at 17 beds for ward three population with 54,000 people who are in low-income housing and another population of 150,000 people, when you're talking about the number of beds per thousand people, it's quite obvious that there is something wrong at York-Finch, it hasn't been allocated the number of dollars for what we would consider a good psychiatric unit.

**Mr. Conway:** Seventeen beds. What's the total bed allocation at York-Finch?

**Dr. Cooper:** Three hundred and twenty.

**Mr. Conway:** Has 17 beds ever been a greater number overall? Is that the maximum it has been?

**Dr. Cooper:** That's the maximum.

**Mr. Conway:** So to those who are led to believe that facilities such as your own could be expected under certain conditions to deal more effectively in the future with the catchment area, you'd say that's unlikely?

**Dr. Cooper:** As a psychiatrist—and I think I'm very imaginative—I can do whatever you tell me. I could even get rid of psychiatric beds. What we're doing now is a Band-Aid approach to therapy. We have beds open, believe it or not, even with only 17 beds, because with 17 beds we can't keep people for too long; all we can do is treat the crisis. We must make sure that people stay in hospital for a limited period of time.

When you look at statistics and figures showing they're short of hospital space, sure, they're short of hospital space; you can make them as long and as short as you want, but it doesn't necessarily mean they're getting the same treatment.

**Mr. Conway:** I presume that, as a psychiatrist, you've had ample opportunity to visit and tour Lakeshore both before and after this January 22 announcement?

**Dr. Cooper:** Yes, I did.

**Mr. Conway:** Would you feel very comfortable about practising psychiatry in that physical plant for many years to come?

**Dr. Cooper:** I would not want to practise psychiatry in any government institution full-time and have to be under them in those circumstances. If I could practise psychiatry as an individual psychiatrist, where I could state what I feel and believe, yes; but you can't do that when you're working for the government.

**Mr. Conway:** You don't feel any of those pressures at York-Finch?

**Dr. Cooper:** Oh, I feel them, but it's a little different. I'm still more independent.

**Mr. Conway:** Thank you very much, doctor.

**Mr. Chairman:** Mr. Leluk?

**Mr. Leluk:** Thank you, Mr. Chairman. I'm going to be brief. I would like to ask Dr. Cooper a question. There has been some concern expressed by members of the New Democratic Party, particularly those on this committee, about the future size of the Queen Street Mental Health Centre. I think you alluded in your earlier remarks to the complexity of a 300-bed hospital and that we're talking now of the possibility of a 600-bed hospital at Queen Street. Do you feel, in your professional capacity, that the size will have some negative effect ultimately on the quality of care at this facility? If that's the case, could you tell us what you feel this would be?

**Dr. Cooper:** Let me tell you the truth instead of playing little games: Queen Street is an ivory tower. The professors there, the assistant professors—there are all kinds of people; it's almost like a corporate structure—are very good people, very well-motivated people. But my impression is that a lot of them are not as much patient-oriented. It's a teaching hospital. It has residents. It's complex enough with a 300-bed unit.

I will give you an example. When I was on the full-time teaching staff at the Toronto General Hospital we had 10 psychiatrists, 11 residents and 40 patients, and we had interns and medical students; but the patients weren't being seen as much as at York-Finch. That's what happens when you are in these ivory towers. You haven't got time for research. What we're talking about now is patient care.

At Lakeshore, you've got doctors who may not have fellowships but who are very competent and working with patients; they may not be that good in terms of teaching or doing research. Lakeshore, from what I have seen—I'm giving you my opinion—is much more functional. As far as Queen Street is concerned, with the additional 300 patients



there, I just shudder to think what is going to happen. Some miracle will happen somehow.

**Mr. Leluk:** I don't think you've answered my question directly. Do I interpret what you're saying to indicate that there will be a negative effect on the quality of services provided if the bed size is increased to 600 beds?

**Dr. Cooper:** Yes, that is my fear. I cannot predict what is going to happen.

**Mr. Leluk:** The Minister of Health, when he was before this committee, indicated to us that the inpatient population in the Ontario psychiatric hospitals has been declining over the past 10 years.

**Dr. Cooper:** That's correct.

**Mr. Leluk:** You'd agree with that statement?

**Dr. Cooper:** I can't deny it.

**Mr. Leluk:** Do you see this trend continuing, even though the population is growing in the province?

**Dr. Cooper:** As long as there is pressure upon psychiatrists, there will be a declining population in hospitals. It's very interesting that there are institutions like the Institute of Living in Connecticut which keep people for a year or two years. If you are going to give good psychiatric treatment and keep patients in the hospital as long as you think they should be, it may even increase. The big problem is the pressure you get from government and the ministry, saying, "Cut beds, cut beds, cut beds." A lot of us follow that and, therefore, it's a self-fulfilling thing. If they said to psychiatrists, "Look, provide the ideal treatment, the best treatment you feel can be given," we might be keeping people in beds much longer.

**Mr. Leluk:** But do you agree that the reason for this declining inpatient population is basically that the modality of treatment is being changed whereby patients are being moved out into community programs, outpatient programs, group homes, and that different treatments are being devised for treating these patients?

**Dr. Cooper:** That's right.

**Mr. Leluk:** Do you see this continuing?

**Dr. Cooper:** As long as the ministry is going to put stress on funding for outpatient services and saying to doctors, "Get them out early," we'll get them out.

**Mr. Leluk:** Let me ask you this question then: Do you see any advantages to treating patients in an outpatient environment rather than in an institutional setting?

**Dr. Cooper:** No, and I can give you examples. For example, drugs are not really scientific in psychiatry. Suppose a patient who has been depressed for six or eight months comes to see me and says, "I'm depressed." Suppose I put him on 50 milligrams of elovil three times a day and he goes to work. He can be zonked until the next time he sees me, which would be next week. So if he sees a psychiatrist twice, a week has gone by.

By bringing a man like that into hospital and perhaps trying out different drugs where you are not worried if he is drowsy or whatever—it is like treating a diabetic—and finally getting the type of medication with which he feels comfortable and it is working, he can be gotten out of that depression sometimes in a week.

**Mr. Leluk:** In other words then, you do not see any advantages at all to having people treated in outpatient programs.

**Dr. Cooper:** I think a lot of these outpatients programs are mainly because people feel it sounds good and it saves money. There are still reasons to keep patients in hospital and to bring them into hospital.

**Mr. Leluk:** But we have heard from other witnesses before this committee statements that are opposite to your thinking.

**Dr. Cooper:** That is their experience; I can only give you my experience.

**Mr. Leluk:** Dr. Cooper, what role do you feel general hospital psychiatric units should be playing in the provision of mental health services in the community? Do you feel they have a role to play?

**Dr. Cooper:** Absolutely.

**Mr. Leluk:** What is this role?

**Dr. Cooper:** I feel that general hospitals can provide consultation, acute-crisis treatment, and if they have enough beds that they can keep patients long enough they can provide very good treatment rather than just Band-Aid treatment. As far as outpatient services go, I feel they can provide that. Day-care services, yes; consultation services and all those things.

It was very interesting when Dr. Roberts went through the history: I also trained in the United States, in Boston, and I really got excited about the community mental health centres there. Everybody was doing everything out in the community. When I came back and went to York-Finch I did not think I needed psychiatric beds. I thought I could do everything out in the community, because I read all the stuff that people were writing.



I have found out now that the community mental health centres are not really delivering as much as they thought they were, if one looks at the literature to see what the literature is saying. In fact we are duplicating our spending. We are throwing away money on these community mental health centres and finding out we have more and more people out in the community who are just as disturbed.

**Mr. Leluk:** May I ask you this question: Based on your views of outpatient programs in mental health services, do you feel all patients who require psychiatric treatment should be treated in an institutional setting?

**Dr. Cooper:** Not all patients, of course not. I feel there are those patients who should be so treated. If I can just go back to the first example I gave, a psychiatrist may see a man who has been depressed for six months and put him onto clovyl. He sees him next week or in two weeks, and he is zonked for two weeks. That man may not be a danger to himself or others, but what he may be saying is, "Look, my depression is so bad it is causing me difficulty and my family difficulty. I am not afraid I am going to kill myself, but at the same time I would like to get this over with as soon as possible." That man is better off in a hospital setting.

**Mr. Leluk:** Right. Would you want to venture a guess—I am not asking for a specific figure but say a ballpark figure—for the percentage of patients who require institutional settings?

**Dr. Cooper:** I couldn't guess.

**Mr. Leluk:** You wouldn't hazard a guess.

**Dr. Cooper:** No. I am not a research man. I can only go with my experience and I would not even hazard a guess; I would probably be quite far out.

**Mr. Leluk:** That is all, Mr. Chairman.

**Mr. Duksza:** Dr. Cooper, I think you and I and our next witness, Dr. Mech, all went through the same period when we went through training in community psychiatry—

**Dr. Cooper:** It was exciting and romantic.

**Mr. Duksza:** Yes, in some sense.

**Mr. Conway:** Duksza, you are not that young.

**Mr. Duksza:** I was close to that age anyway. I went through the same period in which I did—I still, in fact, support some aspects of the community psychiatry movement, but I remember many years back we thought almost every problem could be treated in the community.

**Dr. Cooper:** That is right.

**Mr. Duksza:** I think I have now come to the conclusion that it is impossible in some cases. You are confirming some of these facts for me, that in some aspects some patients, depending upon the diagnosis and the degree to which the condition is chronic, have to be treated in a bed in a general hospital, and others in a psychiatric unit.

**Dr. Cooper:** That is right.

**Mr. Duksza:** You, as a practising psychiatrist, have confirmed what I think is now the new orthodoxy in psychiatry, that you cannot abolish psychiatric hospitals. I was going to file—

**Mr. Conway:** That is the first ray of flexibility I have seen on your part in four years.

**Mr. Duksza:** It is, I have learned something in this committee. I hope you do the same and we persuade the Conservative MPPs that the time has come to keep Lakeshore open.

[5:15]

**Mr. Makarchuk:** Just ignore the interjections.

**Mr. Duksza:** What I wanted to file with the committee before I put some questions, is one article and one report which deal with the question of institutionalization and need for long-term beds in psychiatry. It is an article from Scientific American titled *The Institutionalization in Mental Health Services*. I would like to have it back, but you can reproduce it. The other one is: *Out of Their Beds and Into the Streets*, by Henry Santiestevan, which was extracted from the March 1976 Congressional Reports. That is from the United States, but it deals in some aspects with what has been happening here too, that many long-term patients are discharged into the community without any care.

My more direct question is really for the record. In functioning as the chief of psychiatry in a general hospital, with the network that you have, both the community-based network and the psychiatric beds inside your hospital, could you manage without a backup facility like Lakeshore?

**Dr. Cooper:** I could manage with anything, but to save time the question is how well? This is the problem. A lot of psychiatrists probably take the pressure off the government because we are trying. What is happening is we are cutting to the bone. There is a point at which we are not going to be doing even Band-Aid therapy; all we will be doing is assessments. We will just be taking people, diagnosing them and sending them out into

the community. Then we will have really short stays, of maybe two days or three days.

This is why statistics tell you very little. The most important thing is to get experience with psychiatrists who are out there. If you are talking to academics, you are going to get what the literature says; if you are talking to people who are in government, they may say other things in terms of what they really see; I can only tell you what I experienced and what I see. Let's say a doctor is out in the northern woods and a patient has an appendix which must be removed. He can manage too, but not in the same way he could manage, for instance, at one of the major hospitals in Toronto.

**Mr. Duszta:** Dr. Cooper, have you been concerned with some of the long-term patients who have been discharged into the community and then begin to vegetate? Have you come across many?

**Dr. Cooper:** Sure. I look at some of these homes; and again it is very nice that the statistics say, "Well, he goes to this home and that home." In the first place you are taking a look at patients who are quite disturbed, who require assessment and supervision. In some of these homes, the individuals who are running them have very little understanding of patients, they are doing it on a financial basis and some patients are just allowed to vegetate.

You know, one of the big things people used the term "institutionalization"; but don't listen to that either, that term came about 20 years ago when you used to get a patient to go to the back ward and he stayed there for two years, nobody knew his name anymore. There is nothing wrong with a patient being in a hospital if he's getting good treatment.

What we do at York-Finch, what we would like to do, is keep the patient there as long as we know he is not plateauing out, as long as we see there is progress. Sometimes that can be done in two days; sometimes in six months. It is at that point you must make a decision and say, "We can't do anything further for that patient in hospital, perhaps that is as far as we can go." Everyone thinks the term "institutionalization" is bad. There are prisons; good prisons and bad prisons. There are hospitals which can be like prisons; and there are hospitals which can be very therapeutic. Institutionalization is bad, yes, when the patient is not getting treatment and he is just being forgotten, left just to withdraw; but that can occur in homes too.

**Mr. Duszta:** When I was questioning Dr. Roberts, when I was first listening to him, it struck me he had drawn a magnificent picture of community psychiatry at work and something began to puzzle me. One of the reasons I insisted on having a few questions is because I happen to have gone to Brockville and I know there are patients from the Ottawa region there. Some of them have stayed for one or two years, which is a fairly extended period of time. I said: "How does he manage to do in his area of Ottawa what no one else has managed so far with the long-term patients? How does he manage to do everything no one else has done?" Of course he provided the answer himself by saying: "Well, we have 300 beds in Brockville to which I simply send the patients from Ottawa who do not fit my standard of appropriate psychiatric patients." Off they go, shipped to Brockville. This, of course, rather explodes the whole concept of community-based psychiatry when you have 300 incarceration-type beds there; that is something quite different. In hospitals like that, there is always a danger, and perhaps you would agree, that they will become a total institution, partially because of size and partially because of a lack of staff.

I think the value of Queen Street and Lakeshore, if we keep them the same size as they are now, with the same staffing ratio, is that we have moved towards providing an open treatment while at the same time providing a backup facility for the primary centres with acute beds in psychiatric units.

**Mr. Kennedy:** I just have a couple of questions. When you replied to Mr. Conway at the start, did you say, Dr. Cooper, that you had difficulty in admitting patients to Queen Street?

**Dr. Cooper:** Absolutely. Up to March 1979, it was a nightmare. We almost had a Pavlovian response. If we had to call Queen Street we said, "Who is going to call?"

**Mr. Kennedy:** Were you admitting patients to both Lakeshore and Queen Street?

**Dr. Cooper:** We admitted bed patients to Lakeshore. As far as I am concerned, at times we would be very unfair to the staff at Lakeshore. We would call them about three or four in the morning, when they would be filled up. At the same time, they realized there was a patient in our emergency department, and rather than have that patient lounge around for about eight or 10 hours with his family without anyone knowing what to do, they would say, "Okay, admit him and we will do something." That was not what we got at Queen Street.



In fact at Queen Street we used to get the run-around. I would see a patient, and I think I am a competent psychiatrist—though not the best, my staff is competent—and we would have the patient for about two or three weeks. Then we would say: "This patient is a long-term patient. He requires a longer time than we can keep him at York-Finch."

We would phone Queen Street and they would say they had an assessment team there and ask us if we would like to make an appointment for that assessment team to come maybe in a week or two weeks. Maybe we would go down there with our people or they would come up to York-Finch with their people.

I thought this was like Alice in Wonderland. First I was insulted, because I felt I was competent and that my staff was competent and that surely we knew the patient better than they did. Even if they saw him once, surely they could take our word for it that they should take him and try and do what they could with the patient. If they couldn't do anything further then they should discharge him. This was the difficulty and it was very frustrating.

**Mr. Kennedy:** Did this relate to the mechanism of admissions or was it because beds weren't available?

**Dr. Cooper:** I could never figure that one out, and as I said I could never understand that institution. I must say the medical director there is a lovable man. If you meet my friend, Henry, he is one of the best, believe me. He has been very sympathetic and understanding and I have never heard a harsh word from him. I have only heard empathy. I don't know what it is. I meet the psychiatrists from Queen Street and they are good people, these are all good people; I can't figure it out.

**Mr. Kennedy:** Did you take this up with the ministry if you were having problems?

**Dr. Cooper:** I took it up with Dr. Durost and with the officials from the ministry. I have tried to the point where I began to realize that the place must somehow have some kind of running mechanism itself. I spoke to one social worker last year as I spoke to Dr. Durost. They didn't care whom I spoke to.

**Mr. Kennedy:** When did you take it up with the ministry? Has this been an ongoing thing?

**Dr. Cooper:** I am not on such good terms with the ministry that I can phone and say, "Dennis, it is Jerry." I would call people like Dr. Deadman and Dr. Lynes. I found every-

one was sympathetic to my concerns, but it still didn't change until about March, when I must admit I spoke to Mr. Jappy and the minister; they finally looked into it and did do something.

**Mr. Kennedy:** That is what I wanted to know. You mentioned a March date. What happened in March?

**Dr. Cooper:** Based on what I know, they said I was the only one who had complained and that this was the first time anyone had complained. I can't understand that. Maybe my complaints weren't loud enough. Finally they looked into it and they asked some other people. I understand Mr. Jappy did look into it and he said things would be different.

**Mr. Kennedy:** Is there some committee that deals with this or looks into these things? Do you work with others in this regard?

**Dr. Cooper:** I was chairman of the—

**Mr. Kennedy:** Are you an individualist?

**Dr. Cooper:** Who, me? Not at all; I am a very conservative guy, I hate rocking the boat. There is no one more conservative than I am really, but when things are so unrealistic and everybody knows about it though I think people are afraid to talk about it, it gets to be nonsensical. I always thought community psychiatry means we are being paid by public funds and session fees to be honest with the community. I believe community psychiatry is a matter of education. Tell them the truth.

**Mr. Kennedy:** This seems a resolvable problem. Is it resolved now? Was it something that was just happening with you, not with other psychiatrists? At least they said that you were the only one to complain.

**Dr. Cooper:** I'm the more insecure guy, that's the problem. I'm a very insecure guy. I think I have a healthy paranoia. I can't speak for the other psychiatrists.

**Mr. Kennedy:** Well how are you getting along now?

**Mr. Makarchuk:** You should go into politics; it would help.

**Dr. Cooper:** Never, never.

**Mr. Kennedy:** How are you getting along now? Is it resolved? That's what I'm asking.

**Mr. Dukuza:** The paranoia?

**Mr. Kennedy:** No, not the paranoia. We'll deal with that later.

**Dr. Cooper:** I said healthy paranoia, there's a difference; only a fool's completely trusting.

**Mr. Kennedy:** Okay; when you want to arrange an admission now at Queen Street, how is it going?



**Dr. Cooper:** Oh it's lovely, we have a lovely relationship now.

**Mr. Kennedy:** Good, I'm glad.

**Dr. Cooper:** I ratted on them and what happened is someone from the ministry sat on them until September 1.

**Mr. Kennedy:** So that problem is resolved. So on your earlier response to Mr. Conway at the start of our discussion — well, you've clarified that, but there was a serious problem or a problem with you at Queen Street that seems to be cleared away now.

**Dr. Cooper:** Oh well, I said it would be interesting to see what happens after all the pressure is over and Lakeshore's closed. My knowledge as a psychiatrist, knowing institutions and the rigidity of institutions, is that once the heat's off they're going to go back to their previous philosophy. What we're dealing with is a philosophy at Queen Street, which isn't going to be changed completely because somebody says admit patients. But as I told you I'm probably revealing my own insecurity, that's all. Other people would be more trusting.

**Mr. Kennedy:** The fact is that it's working well now though you've had problems; but you're taking a pretty gloomy outlook that it's going to revert back to the way it was. I don't think that will happen, frankly.

**Dr. Cooper:** I think it's a realistic outlook.

**Mr. Kennedy:** Let us know if it happens, would you?

**Dr. Cooper:** I'm sure if I did—

**Mr. Kennedy:** We'd want to help you.

**Dr. Cooper:** Listen, I'm sure if I did — I've been letting people know for the last three or four years, I was the chairman of the North York Interhospital Committee last year.

**Mr. Kennedy:** Yes, but you've got it solved now, Dr. Cooper. Okay, Mr. Chairman.

**Mr. Chairman:** Mr. Jones?

**Mr. Jones:** I'll be brief. I can't help, though, as a lay person, doctor, as I go through, say Lakeshore and look at that physical plant—and I recognize brick and mortar certainly are not all there is to a hospital; you referred earlier to the heart you found at Lakeshore, and then in reply to Mr. Conway talked about its lack, as you've just been saying to Mr. Kennedy, at Queen Street. But then you also referred to Dr. Durost as a very lovable guy; and you just confirmed for us here that things have clarified. Taking those things in bal-

ance, I'm certain you would agree, as a psychiatrist, that those premises at Lakeshore are really not the ideal physical plant.

**Dr. Cooper:** Let me tell you something: I would say that's not the ideal physical plant; but looking at Queen Street — where I've gone down a couple of times and I've gotten lost — that is not the ideal physical plant either.

**Mr. Jones:** Is Queen Street an improvement over Lakeshore; and we're talking physical plant?

**Dr. Cooper:** It's hard to ask me that, because number one I'm not a patient. You can go into a place and you say, "This place looks nice" and "it's terrific because it's modern"; or, "this place looks old." That may be how you would feel, but patients feel differently. Some patients have said they like Lakeshore, the informality of it.

It's very interesting that at the Metropolitan Toronto East Detention Centre they built near the Don Jail a lot of the guards are unhappy and a lot of the inmates are unhappy. They keep on saying they'd rather go back to the Don Jail. Now you figure it. Just because you build new institutions doesn't necessarily mean that people are going to be happier in that environment.

**Mr. Jones:** No, but I have to admit that as I see them—the swimming pool and the facilities that are part of it, the things for bathing the patients, all that equipment—

**Dr. Cooper:** Wait a minute, they were getting patients better at Lakeshore. But all that's very interesting: we have all these nice things at Queen Street, are we to say now that Queen Street can do a better job than Lakeshore can do because of these things?

**Mr. Jones:** Well certainly as I look at the fact that they couldn't provide electric current for those bathing tubs for patients, even though they are in place; and there are patients who have been transferred from Lakeshore to Queen Street where they're actually utilizing those facilities.

**Dr. Cooper:** Well, shall I tell you something? What's more important is the staff. You know, you could have the most beautiful building, but if you don't have a dedicated, hard-working staff, you've got nothing. Again I would rather take an old building, provided it's safe —

[5:30]

**Mr. Jones:** Well, with all due respect, Dr. Cooper, I spoke with some of the staff there and saw the rapport they had with the patients. They seemed happy, those who

had made that transition, so it all comes somewhat as a surprise. Anyway, I don't see below the surface as you do.

Perhaps you could clarify, Mr. Chairman, whether we are going to have Dr. Durost before the committee, this lovable guy, so we can hear him.

**Mr. Chairman:** Yes.

**Dr. Cooper:** I only say that; I don't think really we should cast aspersions.

**Mr. Jones:** It's such a contradiction.

**Dr. Cooper:** Why?

**Mr. Jones:** This fellow can't bring the heart to the new facilities that I see so improved over Lakeshore.

**Dr. Cooper:** I would say there are some people like Dr. Durost—

**Mr. Lawlor:** You've got lovable guys all over the place.

**Dr. Cooper:** That's right. They have got a very difficult job to do. He is trying to please a number of people. He is a man I have the highest respect for, just as I have the highest respect for Dr. Bond. I would just like to say how the different institutions function.

**Mr. Jones:** But you agree with me. You say to Mr. Kennedy that it is solved now. You have noticed a considerable improvement.

**Dr. Cooper:** To Mr. Kennedy it is solved. He has simple solutions.

**Mr. Jones:** Didn't you say it was solved?

**Dr. Cooper:** I never said it was solved.

**Mr. Jones:** Your admittance problems?

**Dr. Cooper:** I said we haven't got trouble getting them into Queen Street now, that's what I said. But if you're saying that now the problems are over between Queen Street and getting patients admitted to hospital, I just simply say, "let's sit and wait." I don't know; I am a little apprehensive that this good relationship may not last after September 1. I am fighting my own anxieties about it.

**Mr. Jones:** Well, I can't help you with your anxieties. It certainly sounds hopeful to me when you go and see the difference in the physical plant, see the patients in place.

**Dr. Cooper:** You are taking a very simple view of it, which is probably why we got into difficulty in the first place. Somebody thought very simply, "Let's set a date for the closure of Lakeshore. Let's go ahead and we will just ask people." It was a very simple way of doing things, rather than

planning it, thinking it through and looking into it.

If we provided medical services that way you would be shocked and upset. As psychiatrists we try to understand things, and if we are going to take away one treatment we try to see if there is better treatment. We try to reason things out. When you do drug studies, even, it takes time.

**Mr. Jones:** I know a bit about that. I am taking a more optimistic view.

**Dr. Cooper:** I can understand that.

**Mr. Jones:** I am happy for the patients to see the difference in those two premises.

**Mr. Makarchuk:** His choice is rather limited.

**Dr. Cooper:** I have met many people from the Conservative Party who have discussed this, and it is amazing how many optimists we have on that side.

**Mr. Jones:** That's not a bad thing, is it? I sure don't want all your pessimism, I'll tell you.

**Dr. Cooper:** As a card-carrying member also, I can't share that optimism. As I have been saying, it seems to be a very difficult situation where, as a psychiatrist, you feel people are asking you questions and rather than listening to you they are just trying to solidify their position because this is what is politically feasible for them.

I came here stating to you what I believe as a psychiatrist. I am giving you an honest opinion, and this is all I can do. If you want to feel optimistic and happy about this very simple solution that because Mr. Jappy has gone and talked to them at Queen Street it is all settled that way, fine. I don't think it is going to work out. There has been a philosophy there for about 10 years or so; you can ask Dr. Durost. There are four separate hospitals at Queen Street.

**Mr. Jones:** I have seen too many things in my life that do change, thank heaven. I just can't join you in your pessimism that for sure everything is going to be the same as it was. You talked to us today about history—

**Dr. Cooper:** I said I fear it and I am concerned about it. In other words, I don't mind—

**Mr. Jones:** I would like to reassure you, sir, that we on this committee have a pretty open mind about it. While there has been a little triviality and you contributed your share—

**Dr. Cooper:** I honestly don't see your minds that open. I think they are very in-

telligent men at that table, but if they can accept this September 1 deadline for the closing of Lakeshore and feel that just because Queen Street is nicer to us now, everything is solved, I can't accept that or that you believed that either.

**Mr. Jones:** I am looking forward to hearing from the administrator over there tomorrow.

**Mr. Sweeney:** You are very refreshing, Dr. Cooper; healthy paranoia and all.

**Dr. Cooper:** Thank you very much. You don't lose it, that's one thing, or you're in trouble.

**Mr. Sweeney:** I only have one question. Unless I misunderstood you, you seemed to suggest earlier in your discussion with somebody else that you didn't feel you had the resources such as the proper number of beds and staff at York-Finch to do the sorts of things you would like to do for the patients.

**Dr. Cooper:** That's right.

**Mr. Sweeney:** I concur with some of the comments, but if you had more, would it be necessary for you to refer as many patients as you do to Lakeshore, or could you deal with more of them yourself?

**Dr. Cooper:** I think we could deal with more patients. This has always been the difficulty. Right now I think if we had the backup of a good hospital like Lakeshore to provide services we could deal with what we have. There are a few other services we may require, but at the same time I think at York-Finch we have done a very good job for the community. We have worked very hard, and this is what I am trying to get at. One of the reasons we haven't complained is that, really, we couldn't say what we were doing wasn't good medical treatment because we had the backup of Lakeshore, we had this working situation.

Now that Lakeshore is going out of business we have this concern we will not be able to have that backup. We must think about what we are going to do with 17 beds. Suppose the ministry were to say, "We'll give you 40 or 50 beds"; that also involves a lot of money, and at the same time I am not too sure that's necessarily the answer.

**Mr. Sweeney:** Let me put my question in a slightly different context. Do you refer patients to Lakeshore because you believe professionally that's a better place for them to be as compared to York-Finch, or is it because you are not able to provide the kind of care for that patient you feel you

are capable of and would if you had the right facilities?

**Dr. Cooper:** Let me say this. The York-Finch facilities are on a medical floor. There is a pediatric unit, and a coronary unit. When you get a patient to York-Finch, you must make two decisions. One is: Should this patient be admitted? The second is: Is he a type of patient who can be admitted to York-Finch?

If I was at, let's say, North York General, I would probably be sending fewer patients to Lakeshore because of the environment and architecture. There is always that patient who isn't suitable for a general hospital, in terms of either physical needs or in terms of the long-term treatment program. Generally speaking, general hospitals will send a patient to a psychiatric facility like Lakeshore because either the patient might be too violent or difficult to control in a general hospital setting, or because the patient requires longer-term treatment and rehabilitation than the general hospital can provide.

There are some services a psychiatric hospital has that a general hospital hasn't, such as industrial programs and certain other programs.

**Mr. Sweeney:** The reason you send people to Lakeshore is a mixture.

**Dr. Cooper:** That's correct. People are definitely not dumped there. I feel the psychiatric hospital is a very important hospital in the network of psychiatric services. I think more and more people are beginning to realize how important that is. I feel that, if anything, rather than cutting beds we should be adding beds.

**Mr. Lawlor:** Doctor, you, being a psychiatrist, won't mind this question. Are you a card-carrying Conservative?

**Dr. Cooper:** Yes, I am, and I am proud of it. But, as I said, at least I would expect more—I don't want to use the word honesty—but more empathy from the party to which I so fondly belong.

**Mr. Lawlor:** Just one further comment: I think Mr. Jones takes exception to Conservatives being either realistic or pessimistic.

**Mr. Chairman:** Thank you very much, Dr. Cooper. We are into the same old problem. We have two witnesses remaining, Dr. Mech and Dr. Munroe. Perhaps we could call Dr. Mech.

**Dr. Mech:** Mr. Chairman, I cannot possibly equal Jerry Cooper. I'm sure he can upstage most of us.



I represent Peel Memorial Hospital. Perhaps of interest to the committee is the fact that I have developed psychiatric services in Peel Memorial Hospital since 1963. Therefore, I have the benefit of continuity in observing how a psychiatric unit in a general hospital evolves and what the relationship is between a psychiatric hospital and a provincial hospital serving it.

As Dr. Duszta mentioned—and I know him very well from Hamilton days when we both worked together, I too have been one of the very hopeful psychiatrists. We have in a new way entered into marvellous things in the community. When we developed the psychiatric unit in Peel Memorial with 21 beds in 1963 and followed it up with 42 beds in 1969, our interest was purely community-based.

As a chief before co-opting any psychiatrists to my staff, I made one stipulation. I said, "Are you interested in handling all of our patients within the community?" The reasons for that are obvious, namely, the proximity and closeness to the family and to all the community supports, the ease with which one can try to rehabilitate people by sending them out on weekends and longer periods of time and phoning them up. All of my psychiatrists—and there are six of us—had a community-orientation.

I'm sure that Dr. Bond, if he could appear, would confirm that our hospital unit was one of the few units which sent a minimal number of patients to Lakeshore. It was possible for us to do this until 1972-73. In other words, we could do this when our bed ratio was 0.8 to 0.9 per thousand.

Following that time, we experienced pretty much what Dr. Roberts mentioned. Between five and 10 per cent of our patients inevitably entered Lakeshore. We found Lakeshore, as we do now, essentially performing two functions for us. We can handle almost anybody except acute, severely agitated and extremely violent patients whom we cannot handle in a general hospital unit. The second type of patient, who, unfortunately, is being neglected, forgotten, disregarded or shoved under the carpet, but who nevertheless exists, is the chronic schizophrenic. This is the type of individual who cannot function in a community and who would create tremendous disruption to his family, to friends and to community agencies. He can function only in a specialized setting which can take him for a longer period of time and slowly rehabilitate him. These are the two types of patients who require treatment in provincial hospitals, in our experience.

Those are my introductory remarks.

**Mr. Kennedy:** I want to ask one question which I think you touched on, Dr. Mech. Perhaps it's in conflict with our previous witness.

There is quite a reduction in the number of beds and institutionalized patients. Do you feel that the ministry is moving in the right direction in this reduction in deinstitutionalization and in having more community-based programs?

**Dr. Mech:** Yes and no. I would say yes in that a reduction in beds is desirable and has been necessary. A number of years ago hospitals performed a different function—custodial and closer to the usual concept of an asylum. A reduction was necessary because a number of patients could have been handled in alternative settings, approved homes, specialized homes and special follow-up programs, if such were available, but there was a dearth of them.

I say no also because I feel we have reached the bottom line in the type of patient who has been handled in Lakeshore Psychiatric Hospital. I speak of them because I am most familiar with them.

[5:45]

The first problem is what to do with the type of patient who cannot be handled in any alternative setting. One could attempt to develop a network of community agencies. Scarborough was mentioned. It's admirably run and very beautifully organized. However, in our experience from what we have heard of it ourselves and from patients whom we have treated who have been to Scarborough, co-ordination has been a great problem. It's one thing to be able to create community agencies, but it's another to be able to co-ordinate their approaches and their treatments and develop a type of interaction between people who run these places to evolve the type of system which will serve the patients. There are still a number of patients, regardless of the complexity of community services, who cannot possibly be handled either in a general hospital or within a community agency.

**Mr. Kennedy:** With regard to the Lakeshore hospital, as I understand it, the inpatient population in this proposal isn't going to be changed. If you feel we've reached the base where inpatient facilities are needed to the extent they are now, this wouldn't affect that.

**Dr. Mech:** I cannot fully agree with that.

**Mr. Kennedy:** The inpatients from Lakeshore are being moved to two other loca-

tions. But the numbers of those inpatients, other than those in regular programs, aren't being reduced further. If there are 300 at Lakeshore now, then 300 inpatients will remain, except they will be in a different location.

**Dr. Mech:** I have met Dr. Durost at a special meeting to try to co-ordinate what we are going to evolve and how we are going to transfer those of our patients who have to be transferred. What has been of concern to us is that Queen Street is not going to be able to have any buffering beds. They are going to admit every single patient into every single bed they have. It is very well known that you probably need about 15 per cent of empty beds to allow for unpredictable fluctuations in admission rates. They are going to have no buffer of this type.

If they are to have an adequate number of beds, they will be provided by discharging patients whom they have right now. I think what will happen is that a number of patients who should be really treated more efficiently will be treated less efficiently by being discharged into the community.

I might mention that I was on duty a week ago in Peel Memorial Hospital when I had three calls. I had one at two o'clock from Wellesley regarding a patient who had been one of our former patients. I was asked if we would accept her because Queen Street was not able to accept her. So we admitted this lady.

At three o'clock I had another call from Mount Sinai regarding a lady who had been my patient about four years ago. Again, I was asked whether she could be admitted from their emergency to ours because she was our patient four years ago.

Finally, a man who moved to Toronto and lived in Toronto for two years was sent to our emergency in the morning.

In each of these cases, Queen Street was approached and said it could not admit these people. That sent a bit of a shiver of trepidation through me because, regardless of how kind Dr. Durost has been in trying to co-operate with us and offering and promising us to try to admit our acute emergencies, I am sure that we will confront far greater difficulties with Queen Street because of different orientations, which Dr. Cooper has mentioned, and that we will have far greater difficulty than we have ever had with Lakeshore.

**Mr. Kennedy:** I haven't heard about 15 per cent cushion, as you described it, in other statistical analyses.

**Mr. R. F. Johnston:** I raised it yesterday.

**Mr. Kennedy:** That seems high. Of 600 beds 90 would be available.

**Dr. Mech:** Well, I think this is desirable.

**Mr. Kennedy:** Dr. Mech, is this your own personal opinion or is that supported by the mental associations and the profession and so on?

**Dr. Mech:** If you allow for the pattern of discharges, for having to clean beds in between discharges 10 per cent of beds statistically are empty. In fact, you don't have any empty beds. Very few.

**Mr. Kennedy:** Yes, I understand it.

**Dr. Mech:** I speak from bitter experience because in our units we have had 101 per cent occupancy during the last three years. In other words, we invariably have two people in the corridor.

**Mr. Kennedy:** Thank you.

**Mr. Chairman:** Thank you. Mr. Leluk?

**Mr. Leluk:** Thank you, Mr. Chairman. In view of the time, I'm going to be brief, but I wanted to ask Dr. Mech two short questions. Recently, doctor, you spoke at the Peel Social Planning Council meeting. I was there.

**Dr. Mech:** Extemporaneously.

**Mr. Leluk:** Extemporaneously. I think the first statement you made which I would like to have you clarify was that, regardless of what anyone said, there were not sufficient beds at the Queen Street Mental Health Centre to accommodate the present inpatients at Lakeshore Psychiatric Hospital. Would you care to comment to that?

**Dr. Mech:** Yes. I was referring to the statement I made just before, that I am afraid they are not planning for a buffer. They're simply going to admit 600 patients into 600 beds when everyone in the health field knows this is impossible to do. You do not allow for emergencies.

**Mr. Leluk:** I'm talking in numbers from a fact sheet the Ministry of Health issued, I imagine to members of this committee, on April 6. It says: "A substantial number of newly renovated and unused beds have become available at the Queen Street Mental Health Centre as a result of the recent renovation." These include 260 new beds plus a present vacancy rate of 76 beds, for a total of 292. There are also 100 vacant beds which exist at the Hamilton Psychiatric Hospital. This is a fact sheet which was sent to us by the Minister of Health, so I have to assume these figures are accurate. The figures given to myself as to the number of patients being transferred due to the closing of the Lakeshore Psychiatric would number about 208.



Mr. Conway: Mr. Chairman, I think the member for York West is reading from a secret Tory war document.

Mr. Leluk: I don't think so.

Mr. Conway: I don't think we have it, that's all.

Mr. Sweeney: We don't have one.

Mr. Leluk: Well, you know, this was sent to us. It's a fact sheet from the ministry. I don't think there's anything secret about this document.

Mr. Conway: No, no. I just said it facetiously.

Mr. Leluk: Since you made the statement I just wanted to get your views on it.

Another statement was made that what we should be doing as a government is not closing the Lakeshore Psychiatric Hospital, but building a new hospital with 500 to 600 beds. How would a government justify spending some \$50 million plus in public funds to build another psychiatric hospital to serve the Metropolitan Toronto area when we already have a vacancy of the number of beds I've referred to, as given to us by the Ministry of Health? How would you expect a responsible government to justify the spending of those kinds of dollars to build a new hospital facility which would sit vacant?

Dr. Mech: I must speak as a practising psychiatrist and I must speak on the basis of my knowledge of what the field of psychiatry entails. Of course, I'm sure if one discharged 200 patients from Queen Street and sent them out into the community, there would be 200 extra beds there. However, we would be truly depriving patients who have to be treated of minimal care. This would be depriving patients of minimal care.

Actually, I remember talking to Dr. Bond and a committee being formed, because when they had 600 beds they were terribly alarmed they were being cut down to 300. Speaking from what's not ideal but the basic practice of psychiatrists, we have pared the number of patients in places like Lakeshore to the minimum and we are proposing now to still dampen down on it.

Mr. Leluk: But do you honestly believe, as a practising psychiatrist, that we have a need for a new 500- to 600-bed hospital to service the Metropolitan Toronto area, in view of the vacancy rate we have with the present beds?

Mr. R. F. Johnston: On the vacancy rate, as a matter of clarification. Yesterday in a question I asked Mr. Fisher, I think, we established that right now, with the figures

he gave us as to his census from a few days before, that with the new patients coming in they were already at 85 per cent occupancy at this point, not even in the future. I think that was accepted.

Dr. Mech: I'm also talking about what is happening in our community; namely, we're not mushrooming, we're exploding. We're growing very rapidly and we know that in our hospital we will not have an adequate number of beds because we do not have them now.

Mr. Leluk: But, Dr. Mech, we've been told by several expert witnesses, and I refer to these people as psychiatrists, that appeared before this committee that there has been definitely a declining inpatient population in our psychiatric hospitals in this province over the past 10 years. Would you disagree with that statement?

Dr. Mech: I would not disagree with it, but—

Mr. Leluk: How do you justify making a statement that what we need is a new 500- to 600-bed hospital, in view of the statements made before this committee that we have a declining inpatient population?

Dr. Mech: The declining patient population has been strictly due to a philosophy which has not been proven. We have to be very careful that we do not talk in terms of philosophies or theories, but rather that we base our decision on reality. As any practising general psychiatrist will tell you, any psychiatrist isolated from what we feel at times are unrealistic attitudes that prevail just to the west of us, I think we have to base our decisions on the reality.

The reality is that there are great pressures in the field of psychiatry. We feel great financial constraints in general hospitals. We are subjected to grovel budgeting, which does not allow us to hire the type of staff we should have to provide and, I feel, minimal type of psychiatric care—not ideal.

Mr. Leluk: I don't think I've gotten an answer to the question I asked earlier. Do you feel then that we need this new hospital facility you refer to at this meeting, with 500 to 600 beds?

Dr. Mech: Well, if I was a betting man, I feel that I would take a bet that in 10 or 15 years we're going to have very serious discussions—

Mr. Leluk: No, but do we need that hospital today?

Dr. Mech: Today no, but in the very near future, considering the type of population



growth we have in the west, in Peel county, and—

**Mr. Leluk:** So you say the possibility exists that we will need such a facility 10 to 15 years down the road; is that what you're saying?

**Dr. Mech:** I wouldn't be surprised if it were not very seriously considered that a relatively large, psychiatric, provincial hospital won't be required for the area.

**Mr. Leluk:** That's all.

**Mr. Chairman:** Mr. Lawlor?

**Mr. Lawlor:** In the absence of such a new hospital, what is your opinion as to the retention of Lakeshore? If they're not prepared to spend the money now on the facility they already have, the lands and whatnot, I'm presuming they're willing to go to your proposition. If that's not the case, then should the present facilities at Lakeshore be retained?

**Dr. Mech:** Well, we feel great trepidation about the closing of Lakeshore because we know that there will be a shortage of the type of beds which could not possibly be provided in a general hospital, for the type of patient who cannot be treated, because of financial considerations. We are very worried about finances as much as you are and when one sees the chronic schizophrenic patient in a bed in the unit which theoretically costs over \$100 a day, month after month, because one cannot transfer him somewhere, and when we know that this type of patient can be looked after for much less money in a hospital which is slanted to take care of him, one wonders where the wisdom lies in eliminating less expensive beds and expecting that somehow we can treat people in more expensive beds or in a more expensive setting.

[6:00]

I don't feel, by the way, that community psychiatric care, even if it could take care of the more severely ill patients, is going to be that less expensive because the mushrooming of the ancillary medical people in such services is considerable, and invariably such services are flooded by people who are very neurotic or have personality disorders and who simply delight, it seems, in using them. When these facilities are organized, if ever, it will be very difficult to manage the patient population in them. I rather think they will be abused by a certain segment of the population that can be treated less expensively or maybe doesn't have to be treated.

**Mr. Lawlor:** With only 85 per cent occupancy as the optimal occupancy rate—you

mentioned you have to provide for emergencies; there's also another factor, isn't there, the ratio of male to female patients?

**Dr. Mech:** Yes.

**Mr. Lawlor:** That makes it necessary to have some beds available and empty at all times. I've never been able to nail down during the course of these hearings a phrase that you used. In the past your relationships have been with Lakeshore hospital. You haven't had any extensive relations, I would take it, with the Queen Street hospital, except more laterally. You used the phrase, "They have a different orientation at Queen Street." Could you spell that out a bit?

**Dr. Mech:** First of all, Queen Street is a teaching hospital. Therefore, a considerable number of staff in Queen Street are in transition; they are residents or doctors who work for a short period of time prior to obtaining their degrees. There's a rapid changeover in staff; so that, to a degree, I feel the kind of continuity for a patient suffering from a very chronic recurrent illness is disrupted.

When somebody goes to Lakeshore, psychiatrists who work there may have seen this patient 10 years before, or five years before. They know him fairly well. They don't have to spend too much time interviewing him, anticipating what the patient's needs are.

This kind of thing is not really possible in Queen Street, partly because it is a teaching hospital, partly because of the rapid changeover in their staff, but also because it still is a megalopolis core type of hospital. The type of patients who are referred to Queen Street are different from the type of patients who are referred to Lakeshore, and have been.

**Mr. Chairman:** Mr. Jones?

**Mr. Lawlor:** No, I'm not finished.

**Mr. Chairman:** Oh, I'm sorry.

**Mr. Lawlor:** How much time have I got? If I had more time, I'd like to go into that deeply too. Just one question: Have you any thoughts with respect to a 700-bed hospital seeking to accommodate approximately 4,000 outpatients over a period of a year?

**Dr. Mech:** I'm not sure that I understand your question.

**Mr. Lawlor:** The question is whether you have any thoughts with respect to this—from my point of view—monolithic and relatively impersonal organization in its reception and treatment of patients coming from your area?

**Dr. Mech:** Yes, we have considerable anxiety about it. There are certain traditions in medicine which have to do with good practice of medicine. There's no tradition of

being treated in Toronto. There's a long tradition of people in Peel county being treated and accepting Lakeshore as a valuable institution.

**Mr. Lawlor:** Okay. Thank you.

**Mr. Chairman:** Mr. Jones?

**Mr. Jones:** I'll be very quick, doctor. You just talked about the pressures and, as a member from that area and having attended recent meetings which have been alluded to with yourself, I'm aware of them. I'm sure you weren't talking about total health care when I sensed you to say that there was a big shortfall because, as you know, we have this week the directors of a new hospital being struck, we have the opening of a handicapped children's centre and we have a lot of other activities. You're speaking in the psychiatric context.

**Dr. Mech:** Strictly, yes.

**Mr. Jones:** We heard from Dr. Cooper earlier, and it was clear that he was rather pessimistic about the relationship with Queen Street. You alluded to their not having the interaction with people and some of the other things, including the fact that they're a teaching hospital et cetera. But do you join with Mr. Lawlor in getting the squirrel guns out and mounting the ramparts in defence of keeping Lakeshore open? I am talking about the physical plant, but I have to come back to it, because when I go through it, and all the things that I sense socially without having your medical expertise, I am negative about it—does the remedy not rest with Queen Street? Or do you see them just not possible of changing to suit the things that you applaud, and that Dr. Cooper applauded earlier, at Lakeshore? Is that impossible? I am asking that layman's question, if I may.

**Dr. Mech:** Might I give a preamble to my answer? First of all, I don't really see how the true needs for beds can be met by Queen Street. In other words, unless Queen Street expands the number of beds which are available now there isn't any conceivable way that the psychiatric needs of patients from my area are going to be met. What will happen is that we will have a much more severe squeeze on our beds in the hospital and we will be forced to treat for more acutely-ill patients for a much shorter time. What will happen next is anybody's guess. But all of my colleagues in Peel Memorial Hospital look on the future as somewhat of a disaster.

**Mr. Jones:** Doctor, you also said in your recent comments that a great deal of the remedy and a lot of what we should be looking at here was in the community-based things, and you talked about again your con-

cern about dollars. I asked this of an earlier witness but do you feel that the \$1.3 million that has been discussed here would not go a long way towards that?

**Dr. Mech:** It will not go a long way and it also takes a very long time to evolve any kind of well-functioning system. Even if we have \$10 million available, we still could not provide adequate care to our patients during the next—let's be conservative—two to three years. It takes a long time to develop services, to integrate, to develop co-operation between them, and finally to come to conclusions whether much is accomplished by them. We know that Lakeshore is efficient, effective and has performed a very valid function for us.

**Mr. Jones:** Are you, sir, also on a committee of some kind that is to report in September on this subject? I understand that it was mentioned at that meeting you and I attended not long ago.

**Dr. Mech:** I am on a committee, sir, for health councils, yes, looking at the inpatient needs. We have finished with outpatient services now.

**Mr. Jones:** How is it progressing then?

**Dr. Mech:** We submitted briefs regarding what we feel minimal outpatient requirements will be.

**Mr. Jones:** Thank you, doctor.

**Mr. Chairman:** Thank you very much, doctor.

Is Dr. Munroe here? I am sorry, sir, we didn't get to you. I am wondering if you would be available tomorrow.

**Dr. Munroe:** I would certainly try to make arrangements if you want me to be here.

**Mr. Chairman:** Yes, we have Dr. Anderson and Dr. Durost on first tomorrow. Perhaps 2:15 or thereabouts? Would you be available then?

**Mr. Conway:** Just on that, Mr. Chairman. Are we trying to sit from one until 6:30 again tomorrow?

**Mr. Chairman:** Until six.

**Mr. Conway:** I think that's, at a point, highly unproductive, but other members may not share my view.

**Mr. Duszta:** I agree, especially if you have to consistently be here. Could we not accept simply that we will have to sit a little longer than we originally expected and proceed at our usual pace. It is quite right; I think Mr. Conway is right. If you continuously question and listen, five hours is very extensive.

**Mr. Kennedy:** How about one to five?



**Mr. Chairman:** That's quite all right with me.

**Mr. Duksza:** One to five would be better.

**Mr. Chairman:** The only problem is we have nine people listed here as slated to come tomorrow.

**Mr. Conway:** Mr. Kennedy has suggested one to five. I recognize that we do keep falling behind with witnesses. On the other hand I feel that we are in a sense rude to some of our invited guests because some of us just have to get out of the room for five or 10 minutes on occasion. The longer you are here, the more that is required. Notwithstanding all of that, four continuous hours of testimony begin to wear everyone down and I think we are not as attentive or as productive as we should otherwise be.

**Mr. Duksza:** I agree. I think we should simply accept that it will last a little longer than what we originally proposed. It will not be excessively long and nothing like the landlord and tenant hearings, but at least we have to accept that it will last longer.

**Mr. Chairman:** It's quite acceptable to me. I just point out to the committee that it would now appear that if we cut off at 5 o'clock we will not complete it on Wednesday but we will go over into the following week. I just mention that to the committee because it now appears as though that's going to happen.

**Mr. Kennedy:** I was just going to say we have 240 minutes for nine witnesses, which is nearly 30 minutes each. I am wondering if we might not get through most of those.

**Mr. Duksza:** I am not sure when the minister is coming.

**Mr. Chairman:** He's coming on Monday.

**Mr. Kennedy:** But we have a couple of replacements for him.

**Mr. Chairman:** We have Dr. Rzadki, Mr. Bateman, the Ontario fire marshall, Mr. Taylor of the Etobicoke fire department and Mr. Sean O'Flynn and Mr. De Matteo from the Ontario Public Service Employees' Union. I believe those people are bringing along two or three other people who will make a presentation. I presume that the presentation will be made jointly so that all of those people will join together. Then we have Mr. Howard Richardson, the executive direc-

tor of Ontario Mental Health, Audrey McLaughlin, the executive director of Metro Mental Health, and Dr. Olsen, director of outpatients at the Lakeshore Psychiatric Hospital.

Those people have been scheduled. It's not a great chore to reschedule some of them. I am in the hands of the committee. Do you want to proceed on the basis that we go from 1 p.m. to 5 p.m. and, hopefully, try to complete all or most of the witnesses?

**Mr. Duksza:** It would be really impossible to complete it. I suspect that even Dr. Munroe may take about half an hour. The union presentation is the first time they'll be appearing. With the number of people who are coming, that will take longer than half an hour. May I suggest that we can continue next Monday and Tuesday? Then there is the trip.

**Mr. Chairman:** Would it be satisfactory then if we alerted Mr. Richardson, Mrs. McLaughlin and Dr. Olsen that perhaps they should appear next week? That's the last three of the group.

**Mr. Duksza:** What about the trip?

**Mr. Lawlor:** I just spoke to Mr. Conway to say I think we should meet with Mr. Kennedy after this meeting is over in order to have a talk about that visitation. I probably would recommend that we do it a week from Wednesday. I'd like the steering committee to make a recommendation at the opening of tomorrow's session.

**Mr. Kennedy:** Perhaps we could meet after eight o'clock tonight as I am afraid I can't meet right now. I have a commitment. Would you be here this evening?

**Mr. Lawlor:** I wasn't going to be here. I was going to go home.

**Mr. Duksza:** Can I represent you?

**Mr. Kennedy:** Tomorrow morning then?

**Mr. Lawlor:** All right, tomorrow morning.

**Mr. Kennedy:** We'll get in touch.

**Mr. Chairman:** Is that agreeable then?

**Mr. Boddington:** When is the minister to appear?

**Mr. Chairman:** On Tuesday. We will reconvene tomorrow at 1 p.m.

The committee adjourned at 6:10 p.m.



### SPEAKERS IN THIS ISSUE

---

Campbell, M. (St. George L)  
Conway, S. (Renfrew North L)  
Dukszta, J. (Parkdale NDP)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Jones, T. (Mississauga North PC)  
Kennedy, R. D. (Mississauga South PC)  
Lawlor, P. D. (Lakeshore NDP)  
Leluk, N. G. (York West PC)  
Makarchuk, M. (Brantford NDP)  
Sweeney, J. (Kitchener-Wilmot L)

**Witnesses:**

Cooper, Dr. J., Chief of Psychiatry, York-Finch General Hospital  
Mech, Dr. Z. R., Chief of Psychiatry, Peel Memorial Hospital  
Munroe, Dr. A., Chief of Psychiatry, Toronto General Hospital  
Roberts, Dr. C., Staff Psychiatrist, Royal Ottawa Hospital  
Wasylenki, Dr. D., Past Chief of Psychiatry, Clarke Institute of Psychiatry



No. S-10

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Ministry of Health Annual Report, 1977-78

**Third Session, 31st Parliament**

Wednesday, May 2, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.



## LEGISLATURE OF ONTARIO

---

WEDNESDAY, MAY 2, 1979

The committee met at 1:10 p.m.

### MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Chairman:** I see a quorum.

**Mr. Conway:** Are we so impoverished that the Chairman has no gavel?

**Mr. Chairman:** It's part of the restraint package, Mr. Conway. We can't afford a gavel.

First off today we have Dr. Anderson, then Dr. Durost. Dr. Anderson, thanks very much for appearing today. We know that you have been in the wings awaiting your appearance; we are sorry for any inconvenience it may have caused you.

**Mr. Lawlor:** Mr. Chairman, there are a couple of small things before we get started with Dr. Anderson. The steering committee met this morning on a couple of matters. The one I wish to bring to your attention is a proposed visitation to these hospitals, etc. The committee tentatively agreed that next Wednesday morning might be a satisfactory time.

I am particularly anxious that you, as Chairman, since I don't believe you have had the opportunity to view these hospitals, do get an opportunity so to do. You indicated to me a moment ago that the Reed paper hearings are here and you'll be tied up. So I am suggesting Thursday morning instead. I would ask you to poll the members of the committee with a view to seeing who is prepared to visit both these hospitals at that particular time.

**Mr. Kennedy:** Mr. Chairman, I don't think there was an agreement within the steering committee with respect to Mr. Lawlor's proposal, for some of the reasons that he has mentioned. A number of members, quite a few, have already been there; to go again as a committee, it seems to me, might be somewhat disruptive, and unnecessary. As I said yesterday, the members should see the facilities if they are so inclined, but I would suggest they do so on an individual basis or possibly in groups of two or three. I would agree to polling the members to find out what the committee wishes; I don't think it's in

the best interests of all concerned or essential, that we go as a committee at this stage of the game.

**Mr. Lawlor:** This was the very first motion I made—no, it was an incidental comment such as I am making now—when these committee hearings were launched. There was no opposition, obstruction or any difficulty at that particular time and there seemed to be a consensus that the committee should, as a committee, go and visit these facilities. Now if individual members of the committee see fit on their own to visit the institutions, fine; but Lord, you can't sit for days on hearings about institutions in a vague manner out of the blue without taking a look at them. I suggest that would be elementary to our responsibilities.

[1:15]

**Mr. Duksza:** In regard to those remarks, when a committee like ours sits it should not only listen to what other people say, but of course go and visit the facilities, in the way the select committee went to see Inco; and that was in spite of many people having seen Inco.

I worked at Lakeshore Psychiatric Hospital so I know the place. In a strict sense one could say I don't need to visit it, but the situation has changed significantly and I would say even I should go to see it and to talk to people directly.

**Mr. Jones:** Mr. Chairman, like my colleague Mr. Kennedy, I've made it a point to visit both of the institutions and I understand rather clearly that the minister, and certainly the ministry, would assist and aid anybody who wanted to visit as an individual, or as part of a small group of individuals.

I have the same concern that Mr. Kennedy expresses. First off, we all know we would be made welcome, but for all of us to go as a committee I think would clearly be disruptive and I would be opposed to that. I'd like to ask, perhaps, that the NDP members—certainly Mr. Lawlor, I am sure you have been there, have you?

**Mr. Lawlor:** Yes.

**Mr. Jones:** Dr. Duksza mentioned he has. I don't know if Mr. McClellan and Mr. Johnston might have been or not. Have you?

**Mr. Duksza:** I went to talk to the administrators, I mean I didn't talk to anyone else. I went when the decision to close Lakeshore was announced. I talked to people at the Lakeshore and at Queen Street. I met with Dr. Durost in Queen Street and Mr. Fisher and the respective people at Lakeshore, but I don't think it's quite the same.

I don't understand actually what the big deal about it is. Believe me, nothing is going to be more disruptive than closing one hospital and moving all those people. Our little trip is not going to disrupt anything to a great extent.

**Mr. Lawlor:** I don't want to prolong this unduly, but I am really shocked that you should take issue with such a single-minded proposition such as the committee taking a view; even courts do that on occasion. I've been to Lakeshore a hundred times. We went out there at the very beginning when the closing was mooted and I haven't been back except for a couple of community meetings at the site. The information that has been fed to me and what we have heard in evidence given before this committee raises in my mind a whole series of questions and subjects for interrogation. I want to take a look at it in the light of what I have heard. I think we should all do so.

**Mr. Ramsay:** Mr. Chairman, I feel the opposite to what Mr. Lawlor has expressed. I felt at a disadvantage having not been to Lakeshore at the very beginning. I would have been better informed and better prepared to ask questions of the various witnesses if I had gone out earlier. I was discouraged that it didn't look as if the committee was going to go out as a whole, and for that reason and that reason alone I made my own arrangements and went last week to one hospital and this week to the other. I am not prepared to make a second trip after going to that effort.

**Mr. Chairman:** Mr. Lawlor, your motion—is it a motion or a proposal that we go next Thursday?

**Mr. Lawlor:** It has now risen to the dignity, or indignity if I may say so in a committee of this kind where we haven't encountered such obstruction previously, to the dignity of a motion.

**Mr. Chairman:** Mr. Lawlor moves that this committee next Thursday morning, as a committee comprised of whoever wishes to go, attend upon both these hospitals. Are members ready for the question?

**Mr. Rowe:** It's on a Thursday morning?

**Mr. Chairman:** Yes.

**Mr. Rowe:** Well Wednesday is out. I've never been there. I would like to visit the institution, either with one or two or in a group, it doesn't matter.

Would it be just the committee? I was wondering about the disruptive factor? Would we all be going around together? It's quite a large body. Would we be broken up into two or three parts; would there be television there and so on? I think that would be very disruptive.

**Mr. Chairman:** I don't think there would be any television or press. I don't think that's necessary. If there is some feeling on the part of either hospital that a group would be disruptive I see no reason why we couldn't break up into two or three groups and move in that fashion.

**Mr. Rowe:** I agree. I would like to see the physical facilities because we're just hearing about them—

**Mr. Lawlor:** I'm willing to concede that.

**Mr. Rowe:** —although I've been to similar ones many times.

**Mr. Lawlor:** If it appears disruptive we can break up into smaller groups.

**Mr. Kennedy:** As I say, I went on my own and had what I feel was a very thorough tour. I felt quite comfortable with it and feel there is no need to go. We moved through areas where there were patients, and although I am not a medical person it seemed to me that a group going through one of the places where there are patients, a ward or whatever, would have an adverse influence. I can't speak clinically but it seemed so to me.

I just moved quietly through and chatted with patients and with employees at all levels, I have no need to go myself.

**Mr. Jones:** Mr. Chairman, before we put the motion, I would simply like to reiterate that I really don't see the necessity for the motion. The ministry has said very clearly it is happy to facilitate groups of two, three or four, if that's the case, going through. So if there are that many of the members who haven't been and would like to go it seems everything is fine without the necessity of this motion. That will cause me to have to vote against it, Mr. Lawlor, no other reason.

**Mr. Chairman:** The chair is confronted with a motion, so I am in the hands of the committee. I have no alternative but to put the motion.

All those in favour of Mr. Lawlor's motion, please signify?

All those opposed?

Five to five? Are all those voting members of this committee?

**Clerk of the Committee:** Yes, they are.

**Mr. Chairman:** As chairman, and one person who has not been to either facility, I would certainly vote in favour of going to the hospitals. If it is going to be disruptive, I suggest that perhaps we could move through in small groups of two or three.

If that's a problem, then I suggest this be done, because I don't think we want to disrupt the operation of the hospital or the patients.

Motion agreed to.

**Mr. Lawlor:** It's a red herring, this disruption. When doctors go through hospitals with entourages of medical students and others—I mean really, this is an absurd argument. But I agree with you; get it over with.

The second point I would want to make—and I would trust that Mr. Kennedy will just stay at the door for a moment; I didn't realize he was taking such an intransigent stand in this particular matter this morning in committee.

Interjection.

**Mr. Lawlor:** I'll say what I said.

The second thing we discussed was with respect to the report. The steering committee has agreed that we will have all of the evidence finished, I would trust, next Wednesday and that we will sit down and have a discussion in this committee. I offered this morning to draft the basic report. You can imagine how tendentious that's likely to be.

In any event, I'll try to be as fair as humanly possible in order to set out the main points. It will be a very short report and we'll have to meet subsequent to that discussion. That report will be circulated among members of the committee. A future date will be set when the committee will reconvene for an hour or two perhaps in order to discuss, add to, change or do whatever the hell you please with respect to the matter, and then we'll get it into the House. We have to have this in by May 15.

**Mr. Kennedy:** That was your suggestion, Mr. Lawlor, and what you said you were going to do. The other suggestion was that each of the members of the steering committee might put their thoughts down on paper as well and meld the two, or three—merge them. We can do either of those things.

**Mr. Conway:** It is not unreasonable to suggest that when the witnesses have been

heard from the committee, probably as a whole, would meet some time following that afternoon's testimony to see whether or not there are any tentative conclusions that provide the basis for some consensus.

It seems to me if there is an immediate and happy consensus, fine. If there is an early indication that there will be a striking want of consensus I think we can govern ourselves accordingly.

**Mr. Lawlor:** That's what I want to do.

I have a third point: Our information is that next Monday two head nurses will be moved from Lakeshore to Queen Street. I thought we had an understanding with this ministry that no further moves or action would be taken prior to May 15. We were incensed enough to learn that this date was devised for a very self-serving reason in the ministry, but this is a new proposal and a new intention on the part of the ministry.

I would ask this committee, through you Mr. Chairman, to advise the minister that it objects to that; and that it ask the ministry to cease and desist until the report of this committee is submitted or until May 15.

**Mr. Jones:** My recollection is that it is clearly a commitment on behalf of the minister that no further patient transfers should take place. I don't recollect any comment about staff. You say there are two? Is that your understanding, Mr. Lawlor?

**Mr. Lawlor:** Yes: two head nurses are to be moved over. I understood everything was in abeyance.

**Mr. Chairman:** I understood, Mr. Lawlor, that it was couched in terms of patients. If that isn't so, the chair can check that out and I can certainly raise it with the ministry.

**Mr. Lawlor:** May I ask Sean Conway to say what he understands on this?

**Mr. Conway:** I can certainly appreciate your concern. That same concern has been brought to my attention in recent days. But I must say, Mr. Lawlor, it was my understanding that the moratorium was framed in terms of patient transfers.

**Mr. Duksza:** Mr. Chairman, I don't know really what the committee finally will decide, but one of the possibilities is the rescinding of the decision, isn't it? So if this is going to happen, then presumably the minister will have to act on our recommendation and transfer back. It seems so pointless to do it. If everyone has decided what to do, that's fine, but I don't think so. I think this decision is quite open at the moment and it seems quite pointless to me—I don't want say this is bad faith, but even it was not patients, to



me patients and staff are a unit in the sense of delivery of care; I don't want to overstress this again, but it's a little bit bad faith. I think it should be stopped at this moment until we decide. It's only a week after all.

**Mr. Jones:** Surely the predominant consideration has to be the patients. Perhaps some of the people we have with us today might give us some enlightenment as to why those two nurses are being moved, but I think certainly the patients must be a first consideration.

**Mr. Duksza:** There are patients at Lakeshore too.

**Mr. Jones:** Wherever they might be, Queen Street or Lakeshore.

**Mr. Duksza:** That's what I am talking about. It sounds like it is sneaking it in. If we continue meeting for three months, for example, everything will be moved anyway, surreptitiously and quietly while we are sitting here debating.

**Mr. Chairman:** I don't know how one can resolve this at this point, Mr. Lawlor. It's been drawn to our attention. Is there anything further you would wish the chair to do?

**Mr. Lawlor:** I would ask that at the very least the chair communicate with the minister indicating the objection of at least some members of this committee to his moving staff pending May 15 or pending the report of this committee.

**Mr. Chairman:** How would you want me to transport that message, by letter?

**Mr. Lawlor:** Whisper in his ear.

**Mr. Chairman:** All right, I'll give you an undertaking to convey to the minister the concern, certainly of some members of the committee with respect to the two staff members who are going to be transferred.

[1:30]

Just while we are on matters of privilege and points of order and so on, I raised a matter with Mr. Conway, who is a member of the steering committee, and with Mr. Lawlor, subsequent to our convening today, with respect to a number of letters I have been getting from Parkdale people, the Parkdale Tenants' Association and other associations in Parkdale, expressing a concern about the problems out there in relation to housing, illegal bachelorettes and all of those things. I have responded by saying that I will pass these letters on to the steering committee and that we are quite prepared to hear from them if they confine their remarks to the closing of the Lakeshore hospital, but as far as the committee is concerned our terms of reference do not permit us to go beyond

that, and certainly not beyond it to the extent of dealing with what is essentially a city problem. If those people can confine their remarks to the closing of the Lakeshore hospital I am assuming the steering committee would certainly consider their appearance before the committee, but if it goes beyond that I would see no way in which the committee could deal with their presentation.

I just wanted the concurrence of the committee in the approach.

Agreed? Thank you. Thank you very much.

I am sorry, Dr. Anderson, once again we have a delay. Mr. Ramsay?

**Mr. Ramsay:** Dr. Anderson, I am not sure whether this question should be directed to you, or perhaps left for Dr. Durost at a later time, but perhaps you can answer it, or defer it.

Yesterday, at least two of the witnesses expressed difficulties in gaining admission to Queen Street for their patients. I would like to hear more about this circumstance, and I would like to hear your thoughts or those of Dr. Durost in this respect.

**Dr. Anderson:** I would be pleased to comment. In general I would predict that the difficulties in transfer of patients from general hospitals in the Lakeshore catchment area to Queen Street will become more difficult if this move proceeds as is contemplated.

The problem is one of definition of role of the large psychiatric hospital and the psychiatric units in the general hospital. In the last 10 years under the leadership of Dr. Durost, who will be testifying later, we at Queen Street have struggled to define that role and help define that role with the general hospitals in the city of Toronto proper. We have had some difficulties, but through a series of conferences between the hospitals many of those difficulties have been overcome.

It is my understanding that the general hospitals in the Lakeshore catchment area have enjoyed a different kind of relationship with Lakeshore than we have with the general hospitals that feed to us mostly. In what I anticipate to be a long period of overcrowding, I suspect those general hospitals will have increased difficulties in transferring to Queen Street.

**Mr. Ramsay:** The impression left with me yesterday was that when these doctors or these hospitals in the catchment area called Lakeshore they got complete co-operation, but when they called Queen Street there was some difficulty. I find that hard to visualize in view of the fact you had empty beds at Queen Street.

**Dr. Anderson:** The question, as I said before, is a matter of role. The general hospitals historically have felt, and this includes the Clarke Institute of Psychiatry and the old Toronto Psychiatric Hospital, that when they thought patients should be transferred to the psychiatric hospitals they knew best and that should happen. Through long and bitter experience they found that many of their decisions in that regard were wrong. So we have challenged them consistently, discussed the matter with them and tried to work out a solution satisfactory to both of us; as a result, by and large that doesn't happen now, we don't get what we used to call "dumped on" very often.

**Mr. Ramsay:** That problem you described yesterday no longer exists, is that what you're saying?

**Dr. Anderson:** From the hospitals within our catchment area; I can't speak to what's been happening at Lakeshore. As far as I understand it, Lakeshore has been happy to take any referral from any general hospital in their area, with no questions asked. That's not the situation at Queen Street. I anticipate that it will not be the situation at Queen Street in the future.

**Mr. Ramsay:** I don't want to prolong this too much, but can I just ask one further question? Could you elaborate on what you mean by the role of your hospital?

**Dr. Anderson:** There's been a long process of trying to determine what the function of the large mental hospital is, compared to the psychiatric units of the general hospital and such institutions as the Clarke. The McKinsey report goes into it in some detail. It comes up with one kind of solution, which is not unreasonable and everybody agrees with it, that there is an overlap group which can be looked after in the psychiatric units of the general hospitals or at Queen Street; there's another group that belong in the psych units of the general hospitals; and there's a third group that everybody agrees should go to Queen Street. In that middle group there's room for reason to argue, and in that area we've always been less well staffed at the mental hospitals than at the psych units, so that in the interest of our patients we have struggled vigorously to avoid overcrowding in the interests of trying to improve the ratio of staff to patients.

**Mr. Conway:** Just for the record, sir, could you indicate exactly your position, how long you have held it and what it is that you do in that function?

**Dr. Anderson:** I have been a senior psychiatrist at Queen Street since 1960, within

the inpatient department. I currently hold the position of Chief of Southeastern Service, which is one of the three catchment-based services within the centre; the other large service is the Psychogeriatric Service.

**Mr. Conway:** We've heard a lot of evidence, some of it contradictory, about the capacity of the Queen Street Mental Health Centre to effectively deal with that which is going to be transferred to it, assuming the decision of January 22 holds. How do you feel, as someone with that kind of experience in the field, about the capacity of the plant and the staff at Queen Street to deal in the present and future with their new and revised mandate?

**Dr. Anderson:** In the short run there are a number of ridiculous situations arising, but I see no problem in providing adequate care for the patients; not ideal but adequate. In the long run I have a great deal of concern.

**Mr. Conway:** I'm sorry, but how long is the "short run"?

**Dr. Anderson:** One year.

**Mr. Conway:** What are these ridiculous anomalies that you see in the short term?

**Dr. Anderson:** The Southeastern Service, of which I'm the chief, has been looking after a catchment area. We are divided for purposes of doing good community-type psychiatric work, and we look after small catchment areas rather than trying to relate to the whole catchment area. In this respect, Queen Street differs from the organization of Lakeshore. There are pros and cons for both types of organizations. We are very firmly committed to the catchment-based organizational principle.

Southeastern Service is so named because it looks after the patients from the part of Toronto in the southeast end, south of Danforth, roughly, from Victoria Park over to Spadina. The others are Southwestern Service, the west side; and Northern Service, above Bloor-Danforth. The ridiculous thing is that the empty ward in our building is going to be looking after Etobicoke, so we will have a Southeastern Service facility looking after Etobicoke. I will be trying to relate myself to a catchment area that jumps over the Southeastern Service into Etobicoke. That strikes me as ridiculous.

The McKinsey report suggested the expansion of Queen Street's area. It would have been simple for Southeastern Service to extend its catchment area up through East York and the east side of North York without this kind of hedge-hopping, if you want to call it that. Does that answer your question?



**Mr. Conway:** Certainly it does. What are the long-term concerns that you would describe as serious?

**Dr. Anderson:** My experience with Queen Street has been my total professional career and I'm very fond of the place. I'm afraid it's going to go downhill in terms of its ability to meet the needs of its inpatients.

When I started work there, there were 1,200 inpatients. There are now 340. The projection from the Lakeshore area is for a 32 per cent increase in bed necessity for that area. Our hospital is going to be full when this move is completed. Ten years from now it's going to be jammed.

The only way in which that overflow can be looked after is by the development of some kind of community program as yet unpioneered. It is not as though community programs are unknown. The Dundas day centre, which was the first satellite program Queen Street established, was fairly novel in the city, if not in the province and the country. We have been very much involved in community psychiatry and that's one of the reasons the population of the hospital has dropped off. The dropoff in population is levelling out.

I'm not at all sure we're not going to see Queen Street become, in 10 years, a lot more similar to the way it was 10 years ago. We're going to be overcrowded; we're going to be serving a chronic population with very little in the way of acute short-term treatment programs. That is going to result, unfortunately, in radically decreasing our capacity to attract first-class staff. It's probably therefore going to interfere with our connection with the university and our capacity to entertain adequate, interesting research projects that make a hospital attractive to first-class staff.

I can see the place nosediving as a result of a rather short-range saving, which in the long-range could be disastrous.

The only way it can be saved from disaster is in a sense to make it worse, just to make it into a chronic hospital. There are a lot of people in the community who feel that psychiatric hospitals such as Queen Street should be long-term chronic care institutions. We should be more excited and interested in long-term chronic institutions than we are. The young people coming out of psychiatric training programs are gung-ho on short-term treatment. It takes a while for them to become concerned about long-term programs. They're not going to want to work there.

**Mr. Conway:** So there's no question in your mind, then, that the McKinsey report

and its principal recommendation calling for the rebuilding of Whitby and Lakeshore—rebuilding or substantial renovation—is a very justifiable one and one which you would, with considerable expertise, be prepared to support?

[1:45]

**Dr. Anderson:** The serious question I have about the McKinsey report is the assertion that the rebuilding of Lakeshore should take place on that campus. I don't think a modern psychiatric hospital needs to have how many acres of green grass to make it work?

**Mr. Conway:** Mr. Lawlor is the real estate agent.

**Dr. Anderson:** But it's lovely, beautiful; it has much to recommend it as a place to work. That's my only concern. It is beautiful land. Maybe it should be open to everybody. Everybody doesn't feel comfortable walking around a mental hospital yet, I hope they will in another 10 years. But Lakeshore shouldn't move to Queen Street; it should either be rebuilt on site or plans prepared for it to be rebuilt, maybe in the form of units scattered throughout the catchment area.

**Mr. Conway:** As a taxpayer do you have any confidence there will really be any savings in all of this?

**Dr. Anderson:** No.

**Mr. Conway:** Thank you.

**Mr. Chairman:** Mr. Jones.

**Mr. Jones:** Dr. Anderson, you outlined to Mr. Conway your credentials and your extensive years in the field. Could you capsule for us what you feel to be the main force contributing to the inpatient decline in our psychiatric hospitals? Is there any one thing or is it a complex combination?

**Dr. Anderson:** No problem. It's a combination of two factors: Probably the more important initial one was the psychotropic drugs, the major tranquilizers; a scientific breakthrough which made it possible to treat people on an outpatient basis. Patients who couldn't function in the community could now be placed in nursing homes and other kinds of sheltered living situations where they couldn't have been managed before the drugs came along due to the severity of their symptoms.

The other big change was the impact on mental hospital staff of psychotherapeutic attitudes. Psychiatry used to be divided into those who thought psychotherapy was the way to cure mental illness and people who felt drugs and electroconvulsive therapy and other physical methods of treatment were the way to treat mental illness. The latter worked in



the mental hospitals and the former worked out in the community and there was very little overlap. In the last 20 years large numbers of psychologically oriented people have come to work in mental hospitals and have contributed to the advantage being taken of what the drugs offer.

It doesn't always happen. There are hospitals which still have large numbers of chronic patients in them, people they haven't moved out because they haven't taken advantage of the opportunity.

This is one of the things that really bugs me about what's happening. Lakeshore took advantage of that. One of the good things that has come out of this proposed integration of hospitals is that we at Queen Street have come to know Lakeshore and have come to realize how good it is. They have done a terrific job, and they are going to be punished by this proposal. If they had not done as good a job in moving people out, if they hadn't developed a first-class outpatient department, they wouldn't be closing and the rest of the psychiatric community is watching what happens to people who do a good job.

**Mr. Jones:** Doctor, you mentioned that your hospital—you specifically mentioned, I believe, the day centre at Dundas Street as one example of how you have been moving out into the community.

**Dr. Anderson:** Oh, yes.

**Mr. Jones:** So you have a program in place in moving out into the community, correct?

**Dr. Anderson:** That's right.

**Mr. Jones:** I take it, then, your philosophy or your views on community psychiatry are that it is desirable to treat outpatients away from psychiatric hospital settings?

**Dr. Anderson:** Absolutely.

**Mr. Jones:** Now you have, I believe, I am not sure of the term that hangs on the door in the hospital, but you have a "day hospital" I think is the term on the door, in your facility. Is that something different?

**Dr. Anderson:** We don't have a day hospital in the Southeastern Service but at Queen Street we have a day hospital that belongs to one of the other services.

**Mr. Jones:** At Queen Street.

**Dr. Anderson:** Yes.

**Mr. Jones:** So is it just physically there, but that type could be out in the community?

**Dr. Anderson:** We have daycare programs at the hospital, we have daycare programs in the community.

**Mr. Jones:** But you are committed to moving out into the community?

**Dr. Anderson:** We have explored every alternative to inpatient care we can lay our hands on. We are committed to try and do away with mental hospitals, those of us who have lived with the old ones. I think the pendulum has swung too far. We put a lot of people out into the community who suffered from being out there, and we have brought a lot of them back in.

**Mr. Jones:** Thank you.

**Mr. Kennedy:** Mr. Chairman, could I just interject one question or is there somebody else waiting?

**Mr. Chairman:** Is it a supplementary, Mr. Kennedy?

**Mr. Kennedy:** Yes, it is, Mr. Chairman. It just turned into a supplementary. In response to one of the questions Mr. Jones asked and your most recent response, do you see, then, a continuing trend towards the reduction and deinstitutionalization of inpatients? You mentioned perhaps we had gone a little too far.

**Dr. Anderson:** It's very hard to predict, but my impression is that, as Mr. Fisher said the other day while I was here, needlessly, I think we bottomed out.

**Mr. Kennedy:** Yes, that term was used.

**Dr. Anderson:** But no one knows for sure. If we had some elbow room we may find out we can go even further. I am concerned that if we go chock-a-block and morale continues to spiral down we'll go in the other direction.

**Mr. Kennedy:** Whose morale?

**Dr. Anderson:** The staff's morale.

**Mr. Kennedy:** I see; I was thinking in terms of the patients' morale

**Dr. Anderson:** Well the patients' morale is affected by the staff's morale.

**Mr. Kennedy:** Yes; but staff, I suppose, depending on I don't know what factors, are interested in seeing the rehabilitation if that's the correct term, and if—

**Dr. Anderson:** Can I tell you an anecdote?

**Mr. Kennedy:** Pardon?

**Dr. Anderson:** From 10, 15 years ago.

**Mr. Kennedy:** Sure.

**Dr. Anderson:** We had a ward in the old building with 150 patients in it. This is a ward called 6-A that had four bathtubs and four johns and the beds were chock-a-block. The staff had reasonably decent morale and they tried to get the patients out. They'd move them out, and this was a chronic ward, and every time the staff managed to get a

patient out up would come another patient from down below, people we were disenchanted with. So they gave up moving people out because they couldn't get any elbow room. We just changed the rule so that if they got somebody out they could take the bed down and the population in that ward dropped dramatically. You have got to give the staff a break.

**Mr. Kennedy:** Thank you.

**Mr. Chairman:** Dr. Dukszta.

**Mr. Dukszta:** Many of the questions were already asked by Mr. Conway and for that matter Mr. Jones, but maybe just a couple for elaboration.

You have a fairly extensive community program at Dundas, which includes Dundas daycare centre. Do you also provide outpatient services directly in the hospital and in the ward?

**Dr. Anderson:** Yes.

**Mr. Dukszta:** The interest I have in this is that it is not only enough that a hospital, a unit like yours, provides a basic outpatient service in the hospital, and outside the hospital like Dundas daycare centre, but also provides this directly on the ward, which is sort of difficult to define.

Is there a significant percentage of this kind of outpatient service still being provided on the ward? What I mean is are patients coming directly to the ward who really are not fully accounted for?

**Dr. Anderson:** We have 56 daycare patients in Southeastern Service. Southeastern Service has more than the other services—about the same number as the other two put together.

**Mr. Dukszta:** The reason I'm asking Dr. Anderson, is that I know that's how many wards operate in your place and I imagine Lakeshore; so that when the inpatient facility gets closed this difficult-to-define service also begins to disappear.

Where do people go? That's the reason I have brought it out. Could you tell me how many people are you taking care of in your Dundas Street centre?

**Dr. Anderson:** About 60 to 80, I think.

**Mr. Dukszta:** How well is it operating?

**Dr. Anderson:** Magnificently.

**Mr. Dukszta:** Have you had full support for it?

**Dr. Anderson:** I'm not sure I understand your question.

**Mr. Dukszta:** Well what kind of support have you had? We've been talking for a number of days about how community

psychiatry is an answer to many of the problems and that we need less and less beds. In fact we may not need any beds in a psychiatric institution because the community program will take over. Do you think that is likely?

**Dr. Anderson:** Dundas daycare centre was the first satellite clinic Queen Street established. There was no mechanism as to how we put it in the community. Initially we went into the basement of a church; rent free by the way. Two or three years later we were evicted by some government service which said it wasn't adequate and we moved into a central neighbourhood house, a neighbourhood social agency. That agency's job has increased, but we are still in that central neighbourhood house in very inadequate quarters.

The promise of assistance to community-based programs, on the basis of what's happened at Dundas, leaves something to be desired. I'm a little bit suspicious about predictions of good care for the mentally ill based on funding of community-based programs.

Anyway, half the problem with our notion of community-based health-delivery systems is that they save money. We've given people the impression it's cheaper. There's no question in my mind that it's better. Even in a beautiful, modern hospital like Queen Street, who wants to live in an institution if you can live in a small house on a decent street, even if it's a room; but unless you provide the support services for the people who are living there, provide adequate clinics for them and the staff to go and visit them when they don't come in the hospital, provide local programs to assist them in getting sheltered workshop occupation and recreation, it's worse living out there than being stuck in a hospital.

It's a myth that community psychiatry saves money. It's better for the patient but it costs money, and I don't see the commitment on the part of our present ministry to spend the bucks. Everybody wants to save dough and I understand that. I have read a little bit about economics; I don't understand economics, but I know everybody is trying to save dollars to save the economy and so on. However, the people who are suffering most are our patients who are trying to live on welfare. If I tried to live on welfare I'd get depressed. These guys are depressed to start with and we're asking them to give up something to help bolster the economy. I'm digressing now, I'm sorry.



**Mr. Duksza:** Another direct question: Suppose the money is unlimited; how long do you think it will take to develop a program which would allow closing of at least some beds? As someone who has worked with it, do you know how long it takes to develop a support program provided there is a willingness and money is available? [2:00]

**Dr. Anderson:** How long does it take to change the municipal laws in Etobicoke?

**Mr. Duksza:** Good question.

**Dr. Anderson:** Fundamental question. You've got to have a capacity to have the people live in the community they come from when they don't have homes. A lot of them are living in Parkdale because Etobicoke won't have them, and closing Lakeshore is going to increase that number at Parkdale. Parkdale's a great neighbourhood, but it is going downhill and it'll go further downhill in my opinion if the transfer takes place.

**Mr. McClellan:** Mr. Chairman, I wanted to ask Dr. Anderson two questions that maybe haven't been dealt with so far.

You've spoken about your concerns about Queen Street being jammed up and the difficulties you anticipate. The McKinsey report talked about a number of options that were open to it, one of the options being to make additional beds available at Queen Street. They identified beds that could be made available easily, and then another group of beds that could be made available with difficulty. Their assessment was that the difficult beds would be really difficult in terms of dislocation.

I wanted to ask you whether in making 174 additional beds available at Queen Street you could tell whether there had been immediate difficulties with respect to dislocation of programs and these kinds of things.

**Dr. Anderson:** There have been minor difficulties. We can take care of the immediate problem of the patients at Lakeshore moving into Queen Street. They will fill the place up and programs that have been using space that were originally designed for inpatient programs will have to move into space that has to be, as Mr. Fisher explained, in the basement. There's a lot of unused space, that is space available. It's a little bit more difficult but not significantly difficult.

The immediate move is not the difficult thing; it's the long-range prospect that concerns me. The difficulty is convincing the staff that it's a good thing and getting their co-operation and making it work so that the patients don't suffer. There's a feeling

of anger and frustration among the staff that surfaces from time to time, although they've been very good.

We can manage. If we really believed in what was happening, we'd manage a heck of a lot better. And I think we could have believed in the implementation of the McKinsey report, which did enlarge our catchment area and would have increased our bed count, our patient count, significantly but gradually. Hopefully in 10 years' time we would just be reaching a peak if the forecasts were correct. Forecasts are difficult to come by but those forecasts, I'm informed, were derived from McKinsey report personnel interviewing the experts in Toronto at length. I understand the committee has heard some testimony from experts, I hope it's been at length.

**Mr. McClellan:** I've had specific concerns relayed to me with respect to the capacity of the psychogeriatric unit to absorb the psychogeriatric patients from Lakeshore. I gather that those psychogeriatric units—I'm going by memory, I think it's PG-5 and PG-6—

**Dr. Anderson:** Yes.

**Mr. McClellan:** I think they were built for 50 patients each.

**Dr. Anderson:** Unfortunately.

**Mr. McClellan:** Unfortunately, you said? That's what I wanted some comment on. What is your professional assessment of the maximum capacity of each of those wards in terms of quality care?

**Dr. Anderson:** It would probably be less than 34. It is generally accepted that psychiatric wards should be no greater than 30 to 34 in hospitals throughout the centre. A 34-bed ward is standard.

How we got ourselves into the position of 50 beds in the psychogeriatric wards I don't know. They should have probably been 20-bed wards, 50-bed wards are too big.

**Mr. McClellan:** What's the present occupancy of PG-5 and PG-6 now that the patients have been moved over from Lakeshore?

**Dr. Anderson:** Thirty-four, I think. We are trying hard to keep it to 34.

**Mr. McClellan:** What kinds of problems do you get into once you have surpassed acceptable levels of capacity?

**Dr. Anderson:** Would it be enough to say that elderly, emotionally disturbed people are incontinent a lot of the time?

**Mr. McClellan:** Are you able to cope?

**Dr. Anderson:** If there are too many people of that category together in the same ward it is unpleasant for everybody.



**Mr. McClellan:** Are you able to cope with that now; if you are saying 20 is the ideal capacity ceiling and you are up to 34 and 36, are you experiencing problems now?

**Dr. Anderson:** I am not directly involved; I expect it is difficult.

**Mr. McClellan:** Since you are at capacity now, your capacity is—

**Dr. Anderson:** It is psychogeriatric wards, you are talking about?

**Mr. McClellan:** Yes, I'm sorry; within the psychogeriatric wards—

**Dr. Anderson:** We have one 14-bed ward which we expect to open, it isn't open yet.

**Mr. McClellan:** Where do you get admissions? What I don't understand is if you are now virtually at capacity, and you could make a case that you are in excess of capacity with respect to inpatient psychogeriatric load, what happens to admission?

**Dr. Anderson:** Again I am not an expert in psychogeriatrics, but we talk about it a lot around the centre. What we need, in psychogeriatrics are topline, enthusiastic staff who will be able to form relationships with the community that will enable that number of beds to meet the needs of the community.

There is a tremendous demand for a mental hospital with psychogeriatric beds and obviously it is going to increase.

It's true; there's no problem in filling them. If you open a psychogeriatric bed you can fill it. The problem is in getting the interrelationship between the nursing homes, the homes for the aged and the mental hospitals, and good consultation services back and forth; along with good personnel and high morale at Queen Street, good staff; without it you are in the dark ages.

**Mr. McClellan:** There was just one other question I wanted to ask you; we have heard a lot of testimony with respect to the issue of fire safety at Lakeshore; we have heard expressions of alarm and concern around the fire safety issue.

Have there been any fires at Queen Street over the last 12 to 18 months?

**Dr. Anderson:** Yes.

**Mr. McClellan:** How many?

**Dr. Anderson:** In my service I think we have had about four in the last year.

**Mr. McClellan:** What were the causes of these fires?

**Dr. Anderson:** Both accidental, from smoking in bed, and purposeful.

**Mr. McClellan:** Arson?

**Dr. Anderson:** Right.

**Mr. McClellan:** Is there anything you can do about this?

**Dr. Anderson:** We got rid of some mattresses we bought when the place was first built, that were lethal. We now have mattresses which burn, but the gases aren't lethal.

To try to have a hospital where you have a certain amount of freedom and responsibility on the part of the patients, and at the same time try and prevent them from smoking in their rooms is dicey. Something that's a constant cause for concern to the staff of the wards in their interaction with the patients, and the patient councils frequently discuss the problem of smoking. Arson is something else again.

**Mr. McClellan:** How many of the four fires were arson?

**Dr. Anderson:** Of the last two, one was.

**Mr. McClellan:** How recently were the last two?

**Dr. Anderson:** About a month or six weeks ago.

**Mr. Lawlor:** Mr. Chairman, sometimes I like to read from the McKinsey report if for nothing else—it does not necessarily require comment, although I would welcome whatever you have to say, Dr. Anderson—but just to get the thing on the record. There is a large chapter called Master Programs, Long-Term Planning with respect to the whole picture. Saving you a great deal of trouble, time and even thought processes in the matter, at 7-4 it says: "To summarize this chapter, 10-year programs have been developed to help PPHs"—psychiatric hospitals—"to eliminate their essential role." That is "to implement their essential role"; I am sorry. That's a Freudian slip, eh?

"These master programs provide a challenging future for each of Lakeshore, Queen Street and Whitby. However, money will be needed to respond to the challenge. While we recognize that funds may be difficult to free, it would, in our view, be seriously counter-productive to assign an ambitious role to the PPHs and then deny them the resources required to carry out the job. Moreover, so doing may be false economy, because dollars not spent may ultimately result in greater costs in penal institutions and welfare programs. Greater Toronto has a provincial psychiatric hospital system which is excellent by international standards. It should not be compromised."

If you care to comment, or expand upon, or even contradict that, I would ask you to do so.

**Dr. Anderson:** I concur.

**Mr. Lawlor:** You concur.

Doctor, you mentioned, "being dumped on" I think was your phrase. You have long-standing staff affiliated to universities with a particular internal philosophy of mental health and care, and what is necessary particularly, and you have received some criticism before this committee with respect to second guessing—if that's the term—other physicians who refer cases to you. That staff will remain substantially the same. There's no threat of discontinuity there, except that you will have an influx of new thinking, perhaps, coming from the other institution. Would there not be enormous resistance to an alteration in this basic approach? If you are forced to take cases willy-nilly, in a completely open way without a question, will there not be resentments and precisely a sense of your institution being a place upon which you dump individuals?

**Dr. Anderson:** A masterful question. I think the answer is yes.

**Mr. Lawlor:** There'd be resistance?

**Dr. Anderson:** You lost me a little bit.

**Mr. Lawlor:** I'm saying there would be continued resistance within the hospital staff to being used as a dumping place.

**Dr. Anderson:** I think, as I said earlier, I expect that to increase if, depending on politics—forgive the expression.

**Mr. Lawlor:** Let's leave politics out of this.

[2:15]

**Dr. Anderson:** We can choose to relate to the general hospitals in the same way that Lakeshore did, being full and increasingly crowded, which means some other group in the community is going to suffer. Part of the problem is that the general hospitals haven't all achieved schedule one status. In schedule one status they're allowed legally to keep people against their will, to involve their patients on their wards. They're not all happy with carrying out that function and are not all seeking that role.

We like to think we have a part to play in helping develop the full range of facilities in the community. If we have to relate to Lakeshore's catchment area, I don't see why we should change our stance at this particular juncture because some chief psychiatrists in the general hospitals feel that their judgements shouldn't be second guessed. I've been exposed to some of their judgements and I think they should be. Just as mine should be by them. It's a matter of give and take.

**Mr. Lawlor:** Doctor, you have addressed yourself to the possibility of overcrowding, the place being jammed. Would you care to comment on a different aspect of the problem? On what we heard from Dr. Mech yesterday with respect to his area, on the McKinsey projection with respect to population increase and in the light of your grotesquely increased catchment area, have you anything to say about the size of the hospital, and as I understand it, an anticipated 700 beds? The second part of the question has to do with the outpatients, with your ability to contend with service and give adequate care to 4,000 people. That strikes me as an overwhelming burden to impose upon your particular institution.

**Dr. Anderson:** Obviously we'd like not to have the distances involved, but I think that's a small matter considering how mental hospitals in other areas have much greater distances to cover than we do; take Brockville and Ottawa, for instance. I'm more concerned about what happens to the inpatient situation. Mississauga's not that far away from Queen Street, I don't think the distance is a major issue.

**Mr. Lawlor:** I'm thinking of reception.

**Dr. Anderson:** For the police it's a different matter. They're used to just going down to Lakeshore. Now they have to go another 10 miles; they don't like it, but they can adjust to that. The crux of the thing, though, is the overcrowding after a year or two, as I see it, and no confidence that alternate methods will meet the need. I am committed to alternate methods, I have been all of my career. The alternate methods cost money and I don't see the money. I'm not sure you can do away with the need for mental hospital beds completely. I hope so but it hasn't been demonstrated.

In the United States they have closed a lot of mental hospitals, but the pendulum is swinging back and they're opening up again.

**Mr. Lawlor:** Just another comment. I'm going in where angels fear to tread, but I'll say this: I hear doctors, psychiatrists, people I talk to from time to time, friends of mine; some of them are so materialistically minded they believe that drugs are the solution to all our problems, that all mental illness is biologically based. I just want to say bluntly that I don't believe that at all. It's a question of insight into human capability and human character. Certainly, I think a very large number of people can be very much assisted by drugs; and that may be an extended possibility, one wouldn't wipe that out. But there's a hard core of spiritual dis-



affection which can be stigmatized as mental illness which will never, in my opinion, be amenable to that particular kind of treatment. It will have to be amenable to other forms of human deportment and relationships.

I don't know if I want to press you on that; I just want to say that. The business I get from the ministry all the time is that the drugs will ultimately solve the whole problem. I dispute that, deeply.

**Dr. Anderson:** If drugs do solve the whole problem, I hope the savings will be used to enhance the life of the patients, former patients if you like, and not be distributed, willy-nilly, throughout the whole population, which I understand is—

**Mr. Lawlor:** Oh brave new world!

**Dr. Anderson:** —the rationale for us suffering cutbacks at this particular time.

**Mr. Conway:** I have one supplementary question to the one Mr. Kennedy asked, and I thought you supplied a rather interesting answer; I want to be clear about it. In that exchange did I understand you to indicate that from the vantage point of the psychiatric professional community in Toronto—or at least you're part of that—there is the clear impression being left by this government policy, the closure of Lakeshore, that an institution that has been creative and innovative is being penalized for that very kind of creativity and innovation?

**Dr. Anderson:** You're referring to Lakeshore?

**Mr. Conway:** Yes.

**Dr. Anderson:** They're being taking advantage of, I think.

**Mr. Conway:** That's been perceived by at least a number of psychiatrists?

**Dr. Anderson:** Oh I didn't say that; no, no. That's a very personal view. I don't know if I've heard anyone else say that.

**Mr. Conway:** Thank you very much. You've been very helpful, and a patient and courageous witness.

**Mr. Chairman:** Thank you very much, Dr. Anderson. Dr. Durost? You're the lovable man about whom we've been hearing. Would you like to confirm or deny those reports?

**Dr. Durost:** No comment.

**Mr. Conway:** Can you indicate to us who you are and what you do?

**Dr. Durost:** My name is Henry Durost. I am medical director of Queen Street Mental Health Centre.

**Mr. Conway:** How long have you held that position?

**Dr. Durost:** May 1, 1971.

**Mr. Conway:** Prior to that?

**Dr. Durost:** I was executive director of Douglas Hospital in Montreal.

**Mr. Conway:** As medical director at Queen Street, how do you feel about the closure of Lakeshore and what it's going to transfer to your facility, both in terms of patient load and catchment area?

**Dr. Durost:** As you know it's a very complex question. As medical director of Queen Street and from that orientation, the announcement of the closure of Lakeshore filled me with a lot of mixed feelings. Perhaps the initial one was the shock effect of seeing a sister hospital closed and the impact that would have on the staff; people losing their positions and the chaos that inevitably comes, as someone earlier pointed out, from change.

I think, however, it's also been noted, and it's a tenet in psychiatric literature, that crisis and change, although painful, are not necessarily bad in themselves. I think Mrs. Latimer mentioned yesterday that the staff and patients at Lakeshore who moved with the psychogeriatric program anticipated that with considerable foreboding. When in fact they did make the move they found that the circumstances were acceptable. There were some initial difficulties, but these have settled and I think they now perceive this shift, probably, as being an advantage.

As medical director I've been in the hospital since our inpatient population has dropped from 610, I believe it was when I arrived in 1971, to, as Mr. Fisher mentioned, an all time low of 298. Since then the population has drifted up a bit and now it's running around 400 as a result of the transfer of the psychogeriatric program and the fact we've been admitting from west North York since February 19.

Although the impact on Queen Street has been not nearly as disruptive and morale impairing as the announced closure of Lakeshore has been on the staff there, I would agree with Dr. Anderson that our staff also have been disrupted by the announcement. They're sympathetic with their colleagues at the other hospital. However, as Mr. Fisher has said, and Dr. Anderson, although his views are clearly very sympathetic to the recommendation of the McKinsey report and he has serious concerns about the long term impact of the closure of Lakeshore, I believe if people can be brought around to seeing this is something that has happened and staff can direct their attention to resolving the problems created by a decision, then it can, in fact, be carried out.



There are a number of aspects of the McKinsey report—if you'll forgive me for using my notes—to which I think it's probably worthwhile referring in terms of giving an appropriate response to your question, Mr. Conway. I think it was Dr. Wasylenko yesterday who said, in response to a question, in the best of all possible worlds the McKinsey report might be implemented as recommended, and as Dr. Anderson has just stated there would be a realignment of catchment areas; there wouldn't be this jumping from Etobicoke to a Southeastern Service catchment area, which looks a little irrational for starters although our decision to allocate the catchment area was based on coming to a conclusion or decision as expeditiously as we could in order to reduce the amount of confusion, both among our own staff and the staff at Lakeshore with whom we've been working very closely.

The McKinsey report recommended the retention of the three Ontario Hospitals and a very obviously logical enlargement of the catchment area for Queen Street to include East York and west North York, which would have increased our bed capacity or requirements to something like nearly 600, not far from what it will in fact be now. However, I don't think I'm in a position to comment on the economics of the situation in terms of the minister's decision to accept part of the report and reject another part. I think it would be inappropriate for me to do so.

[2:30]

The committee has heard a good deal about the fact that the mandate of the McKinsey report was in fact limited to a role study of the three Ontario Hospitals serving Metropolitan Toronto. I would agree with the comment that this was a very limited and restrictive mandate. It probably would have been preferable to have given the McKinsey company or some other consultants an opportunity to look at the total system of the delivery of mental health services for Metropolitan Toronto, including the three Ontario Hospitals, the general hospital psychiatric units, psychiatrists, other mental health professionals in private practice and community organizations.

I am in full agreement with Dr. Wasylenko's comments yesterday that the solution rarely lies in debates over population size, beds per 1,000, et cetera. The solutions probably lie in fairly radical changes in the way components in mental health systems relate to one another. Perhaps one of the best examples of that is the situation in Hamilton-McMaster where there are four psychiatric

facilities which relate to one another in a very closely integrated system. They're each aware of the inter-relationship and the interface factors. This, regrettably, is not anything nearly as true in Toronto where there is still a tendency for facilities to operate, to a considerable degree, autonomously.

Dr. Anderson mentioned in his testimony that at Queen Street, and I would certainly concur that when I arrived in 1971, to use a term that Jerry Cooper used yesterday, there was to put it mildly, "rampant paranoia" in the Ontario Hospital system, and I think also in the general hospital system in terms of the clashes that were going on between them.

It was in that context it was suggested that we set up interhospital conferences. When a patient was referred from inpatient status in general hospital to Queen Street, we would ask our staff to meet with the staff looking after the patient or we would invite them to Queen Street to look at the pros and cons of a referral. In my view that would provide an opportunity for our staff to interact with the staff of the general hospitals, and at that time we certainly felt that was an advantage. It did help to deal with the point that Dr. Anderson made; and I think it was also made yesterday, and it was certainly made very clearly in the McKinsey report.

In looking at the roles of general hospitals and psychiatric hospitals, it is agreed that the fairly steady increase in the number of general hospital beds over the past 10 years, up to a current level of I believe around 770, with a concurrent reduction in the number of beds in psychiatric hospitals from 4,000 down to about 1,300 between the three, that the number of first admissions to psychiatric hospitals has remained virtually stable throughout that period of time. This would suggest that the increased number of beds in general hospitals has had little or no impact on the need as expressed in the number of patients treated in psychiatric hospitals between 1970 and the present.

I don't know all the reason for that, but the McKinsey report suggests general hospital beds have been utilized for a new type of patient and that there is, in a sense, an open-ended kind of demand for utilization of those psychiatric beds in general hospital psychiatric units. My impression is, and I may be quite wrong about this, that this is perhaps more true of the community hospitals around Metro than it is of the downtown hospitals.

This perhaps is a reflection of the fact that the downtown population, socially and economically speaking, is very different from the population served by the community

hospitals. This perhaps is evident from the fact that Lakeshore Psychiatric Hospital in 1978 admitted something like 2,400 patients from a catchment area with a population of something around 1.2 million to 1.4 million, while Queen Street Mental Health Centre admitted almost exactly the same number of patients from a catchment area of not much more than 800,000, with the Clarke Institute and a number of fairly large teaching hospital units in fairly close proximity.

This would suggest that population figures have to be looked at very carefully. One thousand in North York or in Rosedale are going to have a very different need for hospitalization in a centre like Queen Street than 1,000 patients living south of Bloor-Danforth in the Parkdale or Riverdale areas. Socio-economic factors cannot be ignored.

The McKinsey report makes reference to this, but it's relatively limited. Dr. Anderson mentioned that we have three sub-sectors for our catchment area in the city of Toronto and the borough of York. Northern Services has a population and a geographical area that is at least twice as large as that of each of the other two, South-eastern Services and Southwestern Services. However, Northern Service has been able to provide the required services with 68 beds for about 400,000 people, whereas Southeastern and Southwestern have required between 110 and 136 beds each for populations of 200,000; again, I think, a direct reflection of the fact that socio-economic factors make a difference.

You may feel that is not too close to your question, but if the decision is made to close Lakeshore Psychiatric Hospital, I think it has a bearing on the capacity of Queen Street Mental Health Centre to look after the increased demand for inpatient care, in spite of the anticipated I believe 35 to 37 per cent increase in the population of the Lakeshore catchment area. This cannot be translated directly, on a straight-line basis, into a 37 per cent increase in the demand for services in a hospital like Queen Street or Lakeshore. Population in this area in North America, in Ontario and in Toronto, has been growing over the past 10 years and at the same time demand for inpatient care has been going down. This raises the issue of this bottoming-out factor, and I don't really have any better information than anyone else as to whether this has occurred or whether it will still go further.

The McKinsey report suggests that by "natural means"—bluntly, dying—the chronic population is aging in psychiatric hospitals and there will be attrition on that basis

alone. What is important is whether we are building up a new population of chronic patients. The statistics that are available to us would suggest that is not occurring. At Queen Street, and this is similar to the situation at Lakeshore, the median length of stay—and that is different from the average; I guess most people, where the average is simply taking the total number of days, adding them up for each patient leaving the hospital within a year and dividing it by the number of patients discharged; for Queen Street that is around 34 days. However, it includes people who have been discharged after extended hospitalization. Our median length of stay, which means that 50 per cent of the people who have been discharged have stayed up to that many days, varies from 19 days, which is the longest, in Northern Service; to eight days, which is the shortest, in Southwestern Service. The overall average for the centre is 15 days. This means that 50 per cent of the people coming into Queen Street are discharged within a two-week period, and that compares very favourably with the experience of general hospital psychiatric units, some of which in fact have been reported to have much longer median lengths of stay.

There has been a discussion of the role of psychiatric hospitals. The McKinsey report—which by the way I think is a very well researched report in so far as it was permitted to go because of its mandate—characterizes the patients in psychiatric hospitals as follows: 60 per cent of admissions are male, 45 per cent general hospitals are male. With regard to police referrals; psychiatric hospitals, 20 per cent; general hospitals, two per cent. Involuntary admissions: 30 per cent; actually at Queen Street last year it was 25 per cent; in general hospitals, one to two per cent. Referrals by physicians: one per cent in psychiatric hospitals; 50 per cent in general hospital psychiatric units. OHIP coverage—and this is important in terms of my previous comments about socio-economic status; 30 to 50 per cent of patients coming into Ontario psychiatric hospitals are not covered by OHIP at the time of admission. Two to three per cent of patients coming into general hospital psychiatric units are not covered by OHIP.

**Mr. Conway:** Could you just explain that further a little?

**Dr. Durost:** It's quite simple. I have a bias here, having worked in the province of Quebec where automatically everybody in the population has a little plastic card and the click-click Chargex type of thing in



every physician's office. I had one in mine. Everybody is covered. They have a single card and that stays with them for life. They don't move, either in terms of employer-employee status, or whether on welfare or on old age pensions or what-have-you; they retain the same number. The system in this province is very complex, in my opinion. This means that patients coming in, certainly into Queen Street, frequently have an invalid OHIP number and there is a great deal of red tape and clerical work involved in trying to get valid numbers for these people. Anyway it's important; it suggests, or it simply underlines, that the psychiatric hospital is looking after a different category of patient, socio-economically speaking.

McKinsey also mentions that 50 per cent of outpatients from Queen Street, Lakeshore and Whitby are psychotic, suffering from psychotic disorders, as compared with 10 per cent in general hospital psychiatric units.

What this boils down to is that there is a different category of people. The differences aren't only limited to the fact they are chronic or they have short-term serious problems. There are other differences which seem to direct the stream. I think that's the issue to which Dr. Anderson was referring, and the one in which perhaps Queen Street has perhaps created problems for itself in that it has not accepted on a kind of automatic basis referrals of inpatients from general hospital psychiatric units simply because the psychiatrist in charge of the patient has said the patient should come. We have tended to say that may very well be true, but we'd like to sit down with you and talk about what your objectives are; do we have a special program for which that referral is designed, et cetera.

In the McKinsey report the point is made very clearly. In chapter six, page three, it says: "Changes in the activities of the psychiatric units of general hospitals could influence psychiatric hospital admission rates." [2:45]

Two days ago it was suggested that Mr. Fisher was being overly optimistic perhaps, but he was pointing out that a change in the activities of the psychiatric hospitals relating to Queen Street or Lakeshore, if it's there, or Whitby, might make a very great difference in terms of the need for beds in Ontario hospitals. That would mean that the general hospital psychiatric unit would be looking after more psychotic patients, people with a higher level of disturbance in terms of their behaviour and the apprehension which Dr. Anderson obviously strongly feels about the fact that Queen Street is going to be overloaded, overcrowded with negative effect on

staff morale and so on isn't necessarily an inevitable outcome. Should the decision of this committee or the ministry or whatever lead to the closure of Lakeshore and Queen Street is confronted with the necessity to cope with conditions created by that development, then our situation is such that if, in my opinion, general hospital psychiatric units rethink their role and, as has been pointed out, there are people for whom general hospital psychiatric units is the appropriate setting, there are certain chronic patients and people with special program needs where the psychiatric hospitals are the appropriate spot, and there is an overlap, and occasionally there is noise in the system, the kind of things that Jerry Cooper was talking about yesterday, which I don't think ever will be entirely removed. I am not so sure that it isn't, at least to some extent, a healthy noise in the sense that it does make people continually re-examine where they are at.

**Mr. Conway:** How likely is it that the psychiatric units in general hospitals generally will be able to rethink their role during—

**Dr. Durost:** How likely is it?

**Mr. Conway:** How likely is it that we could expect those role changes to occur within such a reasonably quick period of time as to allow for the alleviation of the sorts of pressures to which Dr. Anderson and other witnesses have drawn our attention?

**Dr. Durost:** I don't honestly think it's possible to answer that. The McKinsey report refers to a study by Prince—and I forget the name of the other author—of the situation in Montreal where the general hospitals were asked to accept primary catchment areas, which meant that the city was carved up into catchment areas in the same sense that the province is carved up into catchment areas for the Ontario Hospitals. At that time I was a regional co-ordinator for adult psychiatric services, anglophone, in the city of Montreal, and I was responsible for allocation of these catchment areas to the general hospitals.

I agree with Dr. Prince that when he looked at the situation five years later there were obviously all kinds of unresolved problems, but my impression at the same time was that if a McKinsey study were done in Montreal they would find that the role of the general hospital psychiatric unit had significantly changed in the direction that I personally feel would be appropriate; that is, that the number of involuntary admissions, the number of patients in this overlap group, short-term, more seriously ill patients would be looked after in general hospital units than



are presently being cared for. One of the things that tends to encourage that is to assign to each hospital a population for which it has primary responsibility.

I made this proposal to a number of my colleagues, chief psychiatrists and chiefs of general hospital units, when I first arrived in Toronto and I must admit I look back on the experience with a lot of embarrassment, because I allowed myself to be, I think, conned into making what I subsequently found to be a—I was certainly beating a dead horse; there wasn't the slightest sign of interest on the part of my general hospital colleagues, psychiatrists and chief in considering this possibility, and the McKinsey report suggested that hasn't changed very much. So reality tells me that my hopes in this area might not be as well founded as I would like.

The other general factor, and this has been referred to repeatedly, is the shift of emphasis from inpatient care to outpatient care. I agree thoroughly with Dr. Anderson that what will be required is a generous infusion of funds, with Dr. Wasylenko in that this should be done on a planned co-ordinated basis, and a possible shift in the role of general hospital units, plus an integrated, co-ordinated, well-financed, well-supported system of community services should make it possible for a hospital like Queen Street, with the number of beds that it has, to pick up the load currently being carried by Queen Street and Lakeshore separately.

I'm not suggesting that that's an ideal solution. There are obviously problems in terms of distance. The police jurisdictions are going to have to negotiate who's going to bring someone from outside Metropolitan Toronto across jurisdictional boundaries to Queen Street and so on, and I think those things can be carried out.

Just a last point and I'll stop. The latest indication in terms of what is happening as far as our capacity to handle the patients we are expecting from Lakeshore Psychiatric Hospital—there was discussion of this yesterday—as of this morning, Queen Street had 413 patients with 458 beds set up. Lakeshore had 125 patients—that is, in those units that are supposed to come to Queen Street—with a 169-bed set up. However, the number of beds set up aren't as important as the fact that on the basis of 632 beds at Queen Street, the 413 that we have this morning, plus the 125 at Lakeshore comes to 538, which leaves 94 empty beds, which would be an 85 per cent occupancy rate.

Mr. Conway: That is an important statistic, and I'm sure Dr. Duksza may wish to pursue it with his professional expertise further than

I. Can you indicate whether or not you foresee as medical director, any difficulty in dealing with the Lieutenant Governor warrant referrals that will now be coming your way?

Dr. Durost: There are at the present time 17 warrant of the Lieutenant Governor patients at Lakeshore. I believe 12 of these are patients who live in the hospital and seven are in the community on loosened warrants. Those 17 patients are included in the 125 that I've just mentioned. We have 23 patients at Queen Street in this category and I think seven or eight actually live in the hospital. So we have a total of 40, I think, as Dr. Franks mentioned, in terms of management, these patients tend to be the least disruptive. They've often been involved in a serious crime; it may have been homicide, or something that serious. In the context of a psychiatric disorder, they spend some time in Penetang, they've recovered. However, they have committed a capital offence and are transferred to a hospital like Lakeshore or Queen Street. Our staff find this group of patients relatively undemanding. Dr. Wayne, who is the co-ordinator of our forensic services, provides these patients with a high quality of care. I do not anticipate that particular group to be a problem.

Mr. Conway: You're saying that with a bed rating of 632, and including today's Queen Street Mental Health Centre's 413 added to the 125 that are presently to be moved from Lakeshore, that allows a total of 538 leaving about that 15 per cent flexibility that a previous witness indicated should be in place in a facility to allow for unexpected admissions.

Dr. Durost: Right.

Mr. Conway: So would you say, as medical director at Queen Street, that you don't really foresee, in the immediate future, any difficulty with the facility for which you are medical director in dealing with the patient load that you've got, and that you'll get from Lakeshore, if this transfer occurs?

Dr. Durost: As Dr. Anderson said, not on the short term. But I think he made a very important point, and that is, if our staff, our clinical staff, particularly, see this move as something that they find unacceptable, bad and demoralizing, and quit, then obviously we'll have lots of problems. From the point of view of medical director and senior clinical staff, we have a major task, not only in integrating clinical staff from the Lakeshore Psychiatric Hospital into Queen Street, but for both groups of staff, creating a climate of working conditions that people will be

motivated to be solution-seeking rather than problem-seeking in terms of outcome. I really have no doubt, and I have a very high respect for the staff in both hospitals, that they would not allow a lot of feelings that have been generated, very genuine and understanding feelings, by this event to in fact jeopardize the care that they are providing the patients.

**Mr. Conway:** Just finally, what about the state of community resources and community-based mental health services in this enlarged catchment area? Do you see very serious difficulties? You mentioned, for example, arrangements the police would have to work out about bringing admissions across certain municipal lines.

**Dr. Durost:** I don't know that that will very likely be a major issue.

**Mr. Conway:** How about other community based related matters?

**Dr. Durost:** I'm at a disadvantage here because I have not yet had an opportunity to read Dr. Lynes' committee recommendations. Queen Street has a program planning committee which is dealing with the ongoing process of implementing and planning for implementing the move of patients from Lakeshore to Queen Street, and maintaining the outpatient services that are presently being provided by Lakeshore Psychiatric Hospital intact, until Dr. Lynes' committee, which is working with Etobicoke, Peel, Mississauga and various community organizations in those areas to bring about a hopefully co-ordinated, and even more importantly, well-resourced co-ordinated system of services.

**Mr. Conway:** Thank you very much. I must tell you that there's a certain uneasiness in my head after having such articulate witnesses as yourself and your predecessor from Queen Street, Dr. Anderson, give me slightly different points of view on the matter.

**Mr. Jones:** Dr. Durost, you've alluded in your comments to the fact that Dr. Cooper, while he said you were lovable, he and Dr. Mech did express concerns, particularly about the admissions, and Dr. Anderson said it as well. You do not foresee any large difficulties with the police adapting, due to the fact that they have to come from Peel—

**Dr. Durost:** My impression is that item would be negotiated between Chief Adamson and his counterparts in Mississauga and Peel, but I don't see why that would be a big problem.

**Mr. Jones:** In these comments that we heard yesterday, I think you alluded to them

as being "noise in the system," and having some healthy side benefits to them.

**Dr. Durost:** Yes.

**Mr. Jones:** They did focus, I guess, on admissions in general. I wonder if you could share with us whether you agree with there having been difficulties there over quite an extensive time, and whether that's been examined since the minister made his announcement about the Lakeshore closing?

[3:00]

**Dr. Durost:** Yes. The situation with regard to our policies and procedures at Queen Street Mental Health Centre have certainly been the subject of considerable scrutiny, since we recognized that Queen Street had acquired a reputation, because of its approach to the issue of requests for transfer of patients, particularly from inpatient status in general hospital to Queen Street, and there have been from time to time problems, disagreements.

Dr. Anderson pointed out that the Inter Hospital conferences had helped to resolve those. We've worked more intensively with some hospitals than others. I think if you contacted those hospitals you would find their satisfaction level has improved. However, as Dr. Cooper and Dr. Mech pointed out, having had what they regard as very smooth, comfortable working relationships with Lakeshore and having heard that Queen Street isn't as easy a place to get patients into, they were, I suppose very understandingly, apprehensive.

We invited the chiefs of psychiatry from the four general hospital psychiatric units in the Lakeshore catchment area to Queen Street to put this issue on the table. We have indicated to all of them we would like to monitor with them any problems they might encounter. My experience has been that it's less difficult to deal with blanket statements like "Queen Street is difficult," than it is with patient A, B or C with whom some specific referring agency has had a problem.

Dr. Mech referred to a couple of patients yesterday with whom he had had difficulty. I spoke to him about it after the hearing was over and spent a couple of hours last evening trying to track down who the patients were, when they were referred, who received them and so on. Unfortunately I got my signals crossed, or at least had my dates wrong, so after having talked to residents at Mount Sinai, Wellesley and Queen Street I never did locate who these patients were and what the circumstances were.



**Mr. Jones:** I also took from the comments of Dr. Cooper and Dr. Mech yesterday that one of the reasons they felt some disquiet about Queen Street versus Lakeshore was the fact it was a teaching hospital, as they referred to it. Could you expand on that for us, please?

**Dr. Durost:** I think it was Dr. Cooper who referred to Queen Street as a good example of the ivory tower, a rather cold-hearted institution more interested in its medical students, its residents and its research than in patient care. With all due respect to Dr. Cooper, I couldn't disagree with him more. I think the clinical staff at Queen Street is excellent and their orientation and concern for patients is of very high quality.

My own conviction is that the responsibility for teaching medical undergraduates, residents in psychiatry, and students in other mental health disciplines, is an excellent motivating factor for all; for example for the psychiatric staff to be up to date with regard to their current scientific literature and on through. There is nothing quite as challenging and stimulating as being exposed to a group of young, cocky medical students who can put you on the spot in very short order if you're not up to date as far as your reading is concerned.

As a general statement I would say, and I'm not denigrating in any respect the quality of care being given at Lakeshore or Whitby or other non-teaching psychiatric hospitals, my own personal belief is that in a hospital, teaching and research activities are bound to augment the quality of care received by the patients in it. I'm talking about Queen Street. I can't say that necessarily obtains in other settings; I'm quite sure I have a bias in this regard.

We are able to attract a staff who are well trained, who are of high quality and would not come to our hospital if we did not have the status of an affiliate teaching hospital in the University of Toronto network. There is a kind of dichotomy here that is regrettable and one would hope to see it minimized. I should stop at that point because I will get off into some of my own mythology.

**Mr. Jones:** As you heard at the opening of our proceedings here today, we are going to be hearing from some people in Parkdale with comments about how they feel some of the community-based group homes will affect their community, and I noticed Dr. Anderson's comments about how that is largely a borough matter and so on. However, from your point of view, do you have any com-

ments on this that might help us as we prepare to meet these people?

**Dr. Durost:** There is a well-known phenomenon of drift particularly with regard to long-term psychiatric patients who become involved in almost indefinite support programs, sheltered workshops, extended daycare programs and so on. The patients tend to move closer and closer to the hospital, which is the major source of their support. This is one of the reasons that Queen Street has, since I have been here—Dr. Anderson mentioned the Dundas daycare centre was established in 1968—since then we have established a community in Archway and Spectrum. We participate in the Keele clinic; York community services, which we inherited from Lakeshore when we absorbed the borough of York; and we have very recently established what is called PACE, a satellite unit working in the east end of the city with psycho-geriatric patients.

There is a purpose in doing this. If we subdivide like an amoeba and plant satellite programs around our catchment area, away from the parent hospital, we provide accessibility to the population where the satellite unit is located. It also tends to discourage patients from drifting back and maintaining a dependent relationship on the parent hospital. By doing this we have helped to reduce the number of our discharged patients from filling up boarding homes in the Parkdale area and they are perhaps more evenly spread through the city of Toronto and the borough of York; the city of Toronto certainly, I am not sure about the bylaws in the borough of York.

The Lakeshore Psychiatric Hospital, unfortunately, has not had the privilege of having group homes available to them because of zoning regulations, as I understand it, in Etobicoke, Mississauga and Peel. As a result, they have been forced to place over 200 of their discharged patients in boarding homes in the Parkdale area. As someone pointed out, in the final analysis, whether a patient receives his inpatient care at Lakeshore or at Queen Street, if when they leave the hospital the only area in which it is possible to locate happens to be an area like Parkdale, whether they are coming into Parkdale from Queen Street or from Lakeshore isn't going to change the actual volume of the number of people requiring such accommodation.

I would very much like to see opportunity for the placement of co-operative housing—programs like Houselink, co-operative apartments, approved homes, et cetera, in areas outside the city of Toronto. Whitby Psychiatric Hospital does exactly the same thing; it



discharges patients back into the city of Toronto. My personal feeling is that if I lived in North York, came to Queen Street Mental Health Centre for the inpatient component of my psychiatric treatment and it was recommended that rather than going back to my family, or if I didn't have a family I couldn't go back to live in my borough or municipality because it didn't allow group homes and I had to live downtown in an area already overcrowded; I think as a citizen of that borough I would probably kick up quite a fuss. But as has also been pointed out, psychiatric patients tend to have a very low profile and very little clout until situations such as the one we're engaged in occur at irregular, and perhaps, infrequent intervals.

**Mr. Jones:** Just one final question, if I may—and incidentally I thank you, as others in the committee have for the update of these figures you've given us as to the actual bed ratings and patients.

However, in this comment about sizes, we've noted from some of the members of the committee, and I think it's fair to say particularly the NDP members of the committee, that they're concerned about the future size of the Queen Street Mental Health Centre. Can you just share a closing comment with me? Do you feel there will be some negative effect on the quality of care at Queen Street given the sizes you can foresee?

**Dr. Durost:** I don't think that can be ruled out. As medical director, as I said at the outset, if I had my druthers I'd sooner be medical director of a 300 or 350-bed hospital than medical director of a 600-bed hospital. However, if this is the way things will be, we're fortunate in having our treatment services organized into geographically circumscribed catchment areas. We do have a Northern, Southeastern and Southwestern Services areas. Each of those will have 150 beds. Psychogeriatric services will have 150 beds, so in some ways we'll have four semi-autonomous clinical units. Within each of those units there will be an assessment crisis unit component, intermediate stay, long-term stay, and specialized programs such as the revolving door program to which I believe Dr. Wasylenki referred yesterday.

This means that while it's complex—and the larger any organization is the more problems one has in co-ordinating and maintaining clear lines of communications, clear lines of accountability, et cetera—my own feeling is that if it has to be I would prefer, if I had to look after a 600-bed hospital, I would prefer to look after it on the basis of four semi-discrete entities than I would a functionally organized hospital, with all one

structure relating to an extremely large catchment area.

**Mr. Jones:** That is dealing with the headaches for you, but what about the quality of care? This breaking up into four entities, do you feel that helps you ensure quality of care?

**Dr. Durost:** If I look at Northern Services, for example, which because resources have been limited has had two 34-bed units in a small day hospital—you may not recall the figure but the median length of stay there is 19 to 21 days—my impression is that has been a reflection of the fact they've only had two wards and those wards, of necessity, have included long-term, short-term and intermediate-term patients. They will, if this closure proceeds and we expand our programs, have median length of stay from 20 days down to 10, perhaps. Quality of care isn't necessarily measured by how short a time the patient is kept in hospital, but at least by using that measure, however questionable it may be, in that sense I think the quality of care will not be impaired.

**Mr. Jones:** Thank you very much.

**Mr. McClellan:** I just have one supplementary on your response to Mr. Jones' question. You indicated you would anticipate having four 150-bed units, one for each of the geographic sections.

**Dr. Durost:** Three per geographical and one for psychogeriatric care.

**Mr. McClellan:** Okay, that is where I was confused. I thought you had said four plus psychogeriatric.

**Dr. Durost:** No.

**Mr. Chairman:** Are you finished, Mr. Jones?

**Mr. Jones:** Yes.

**Mr. Chairman:** Mr. Dukszta.

[3:15]

**Mr. Dukszta:** Dr. Durost, I agree with what you said both from the point of view of being a medical director and as one who has been concerned about psychiatric patients and has developed and instituted psychiatric programs, that you prefer a smaller hospital directly based in a community. It fits into what I think has been the accepted mode of delivery of services in this province since the joint commission wrote its monumental study.

As an aside, are you old enough to have participated in the Tyhurst report, like Dr. Charles Roberts; or is that a little beyond you?

**Dr. Durost:** Just before me.

**Mr. Duksza:** Of course it was in itself a monumental study, but not quite as large or as important as the joint commission, but nevertheless of some importance. Yesterday we were privileged in having Dr. Roberts, who instituted this system of moving general delivery of psychiatric services to general hospitals while allowing for the long-term chronic and multi-disadvantaged patients to be of course treated in a psychiatric hospital.

He in fact confirmed, yesterday, that he had two types of treatment; what he called community-based, general-hospital-based treatment in the Royal Ottawa Hospital, and then of course the backup facility, to use his terms, of 300 beds in Brockville—sort of slightly out of sight out of mind, but nevertheless that was to take care of all the things which, according to him, could not really be dealt with in a psychiatric unit in a general hospital or in a type of hospital such as the Royal Ottawa Hospital. In effect it fitted in very well, especially since he was one of the designers of the Tyhurst report.

I must be stimulated by the way you answer because my question is almost as long as some of your answers. Let me continue, if I may, Dr. Durost.

It took many years to develop the present approach in which you differentiate between a general hospital unit and a psychiatric hospital which then operates as a backup facility.

One of the things which struck me was a statement in which you suggested that the chronic patients on the whole tend to be much older than the others. Am I correct or not?

**Dr. Durost:** I didn't suggest they were older.

**Mr. Duksza:** No, but you suggested there is a natural—I didn't quite follow it then; there was an attrition rate of the chronic patients?

**Dr. Durost:** I made reference to the fact that this is based on studies done in Britain, which were subsequently found to be not well founded. When they were trying to anticipate the number of long-term psychiatric hospital beds that would be required in the UK, Tooth and Brook did a study and estimated there would be an attrition rate, either due to discharge or death of patients over the succeeding 10 years; on that basis they incorrectly concluded that there would no longer be a need for any beds for chronic patients.

**Mr. Duksza:** I was quite aware this was a methodologically incorrect study.

**Dr. Durost:** Very unsound.

**Mr. Duksza:** Very unsound, but you quoted it nevertheless. It left me with an impression that most chronic patients are affected by the institutionalizing effect and that if we prevent this institutionalizing effect, which occurred in the 1940s and 1950s and prior in psychiatric hospitals, we will have fewer chronic patients. But the rebuttal of that study suggests that, and I hate to say it, maybe one in four of those people diagnosed as schizophrenic, in spite of all the often best possible community-based psychological and phenothiazine treatments, still tend to deteriorate—not as extensively as they used to in Kraepelin's time, but nevertheless they deteriorate—to degrees that they become in need of extensive rehabilitation, retraining and institutional services. So in effect we cannot say now, just to finish up on that study because it really has no longer been accepted, that there would be no chronic patients. There will be chronic patients and they will have to be taken care of somewhere, am I not right? And this is, in effect, going on presently?

**Dr. Durost:** It is correct there is a proportion of individuals diagnosed as schizophrenics, with schizophrenia, who unfortunately fail to respond to current pharmacological methods of treatment and others. However, this does not mean they need necessarily be best accommodated in a hospital setting.

**Mr. Duksza:** Oh, yes.

**Dr. Durost:** Given the proper support systems; again as Dr. Wasylenki pointed out one of the crucial aspects of this is proper housing and an adjustment of government regulations which would allow the type of housing that is available to psychiatric hospitals to be extended to general hospital psychiatric units. Again one might alter the pattern of activities in general hospital psychiatric units.

**Mr. Duksza:** Well in that sense we are in agreement; I mean in saying if we had alternatives. I think we are in agreement that you will always have a need for a bed, except that the bed may not have to be occupied for longer than a couple of weeks. It should be there available for a patient to come in and out, but the basic treatment and rehabilitation retraining should always be done in the community. We are talking about a third revolution, almost in the sense that we need now an intensive capital in-



vestment and also new technology of dealing with people entirely in the community. This has also been recognized in the United States and elsewhere. In effect there is no new technology and it tends to be wishful thinking on the part of many community-oriented psychiatrists, of whom I have known many, to think that we could do this, unless as Dr. Anderson pointed out there is a significant investment in community facilities, which in the long run are as expensive in some sense as institutions; or better as he points out, and I agree; and which are not available at the moment.

**Dr. Durost:** I'd like to comment on that for a moment, I think it's an extremely important point. Investment and provision of funds for community support services is not enough in itself. Obviously, as Dr. Wasylenki said, you need co-ordination, you need planning. I think for me the key word is commitment to clearly stated objectives for those organizations which are in receipt of those funds. The general hospital psychiatric units, according to the McKinsey statistics, have not, in fact, had a significant impact on the workload of the Ontario hospital system because their funds have been utilized in an open-ended way for a different category of patient. And as it suggests, the utilization rises in something along Parkinson's Law to meet the availability of resources—the more beds there are the more psychiatrists there are, the more people who will be treated.

**Dr. Munroe** is sitting behind me and will probably be testifying. He'll have an opportunity to comment as the chief of the Toronto General Hospital psychiatric unit. But I think this is a fairly widely deserved comment.

**Mr. Duksza:** Well, that's a very interesting point you brought out, Dr. Durost. I agree with you, that, in effect, the psychiatric units in general hospitals expanded themselves and provide service for another whole set of problems and, in effect, left the provincial psychiatric hospitals dealing on their own once more. We have already established there is a whole lot of chronic patients which are dealt with by the psychiatric hospitals—

**Dr. Durost:** May I interrupt at that point?

**Mr. Duksza:** Yes.

**Dr. Durost:** What I am concerned about is that the same phenomenon might, if proper controls are not maintained, occur with the funds that are invested in community programs; they will again be di-

verted to a different category of patients which, in fact, will have little or no impact on the ability of the Ontario hospitals to look after their outpatients who are seriously, chronically ill, maybe unattractive, odd—whatever.

**Mr. Duksza:** You share that position entirely with Dr. Anderson who has a real concern that would happen and the basic mainstream of the services provided for the long-term and chronic patient in a psychiatric hospital won't be affected. That was his main fear. He really didn't say what will happen, he just said that according to our available knowledge, the real danger is that this group which is in some sense disenfranchised—I mean, they are not as able to speak, you clearly said that 30 to 40 per cent of them have no OHIP at all. They are often not even able to think of getting it because of the particular psychological and psychiatric illness. So it's our responsibility to continue providing a broad spectrum of services which are based, at the moment, largely in the provincial psychiatric hospitals, so it's very difficult for us to think now of removing this. Potentially, one of your fears is diverting the source of funds for provision of mental health services for people who are already, in effect, getting enough and, consequently leaving those people who need it most without a real support system.

You have also pointed out that the people who get institutional care live very close to the hospitals, so the greater the concentration of hospitals we have, the more the periphery will suffer. A good example, of course, is my own riding, and ward 2, in which we have, over a period of many years, discharged a number of people from hospitals and people simply are not taken care of, either in terms of retraining, rehabilitation, or aftercare or anything whatsoever, just forgotten. If those people don't have centres with which they can closely relate, like Lakeshore, Queen Street, and Whitby, it will produce a new pressure on just that one centre. Finally it will be impossible to maintain these people in quietude without any support system. This is the thing which we are now concerned about cutting off.

Did you want to comment or can I—

**Dr. Durost:** I guess I share Mr. Fisher's optimism that it doesn't necessarily have to be that way.

**Mr. Duksza:** Oh, I am also.

**Mr. R. F. Johnston:** Mr. Chairman, I have a supplementary on this before it slips by totally. That was to do with the money going



into community services and your concern about lack of focus, if you will, or lack of co-ordination. I wasn't sure if I got a hint or not of your concern for the way health money at the moment has gone into some of those outpatient kind of services. Do you see that in fact, in the past we already have a lot of examples of money maybe not being as focused as it should be and not given proper emphasis on the outpatient services in the community?

**Dr. Durost:** It's not easy to answer. I was on the board of Community Resources Consultants from whom we've had testimony, I remember Mrs. Best. That group has directed its attention towards finding social programs, recreational programs, and most importantly housing programs for patients being discharged from the Clarke Institute, general hospital units, and Queen Street. And I have the highest admiration, albeit biased, for that group in terms of their perception of the need to concentrate the resources on those people with the greatest need, the people with the least ability to cope with the demands of life in the community. Some of the other proposals for funding that I have seen go by in terms of my membership on other committees have looked as if they held less promise with regard to this hard-core group.

I guess I made more than enough points in my initial comments but one of the things I did miss out was the fact that whether or not Queen Street will be able to cope with the increased workload will be, to a considerable extent, a function of the readmission rate. First admissions have remained constant, readmission rates have gone up as high as two out of every three patients coming into the hospital. And it is generally felt that that is a function of inadequate community support services.

So, our ability to cope will be to a considerable extent a function of success in reducing the readmission rate. I think personally it can be reduced with a co-ordinated planned application of resources to appropriate community support services.

[3:30]

**Mr. Lawlor:** Has it anything to do with premature rejection of the patient?

**Dr. Durost:** That is a valid question and is one that troubles professionals in the field. We're constantly trying to walk a tight-rope between keeping people too long and inducing undue dependency on the institutional setting and sending the patient out too soon.

We've set up at Queen Street—Dr. Wasylenki referred to this as one of the programs to which he sends patients—a revolving door program which is addressing itself specifically to the problems that appear to be particular or peculiar to those patients who require repeated readmissions. There may be something about them that is perhaps not related to how long they stay in, but to other qualities of their illness, their personality their family resources, et cetera, so it is a matter under study.

**Mr. Duksza:** How much would it all cost to produce, in your opinion—we talk glibly maybe about the provision of community-based services in community housing, occupational therapy, retraining, sheltered workshops—to be able for us to move to cancel some of the beds? What is your impression about the costs, and how many years do we need to introduce them?

**Dr. Durost:** I will take Dr. Anderson's fifth amendment; I'm not an economist either. The \$1.3 million that has been stated is available for the development of community support services in the Lakeshore catchment area is, in many ways, to me a somewhat meaningless figure. I see large budgets going by with regard to day-care programs, partial hospitalization programs, et cetera, which I fully approve. They tend to be expensive. I guess one can only say that probably no amount that will be made available will be enough.

**Mr. Duksza:** You are talking of Dr. Wasylenki. Dr. Anderson was the first one who said that basically it cost as much except that it's better to do it now. He also said that it isn't there. Do you agree that it would cost as much to do it, in effect?

**Dr. Durost:** To provide these programs?

**Mr. Duksza:** Yes.

**Dr. Durost:** It costs well over \$100 a day to look after an inpatient at Queen Street. I think you referred to a study yesterday from Scientific American on deinstitutionalization and the fantasy that it would be cheaper to move people out of hospitals and support them in the community. That myth has been exploded. It costs as much, if not more, but it's money well spent.

**Mr. Duksza:** Yes, I am in full agreement, so \$1.3 million, coming from a larger budget which was originally Lakeshore, allowing for the fact that some would have to be to help you in Queen Street, is in fact both a very small and meaningless figure, because what we will be taking a real risk with is the

number of patients. Am I not right? You're nodding. I would like you to say.

**Dr. Durost:** Maybe I had better get you to repeat what you said. My nodding is becoming Pavlovian.

**Mr. Chairman:** I want to alert the committee to the fact that we have been going over two hours. We have had two witnesses, and I still have Mr. McClellan, Mr. Lawlor and Mr. Kennedy on my list. We have four witnesses plus the union people yet to go and we have an hour and a half left. So I would implore the committee to act accordingly. That's all I can say.

**Mr. Dukszta:** Three or four questions and that will be it. This time I will be very short. To return to the point, I am in agreement that to treat, to help an individual, a chronic individual in the community costs about the same amount that it would cost in an institution, so what I am saying is that you really have to give infinitely more than \$1.3 million even to keep up with what the present thing is.

**Dr. Durost:** Yes.

**Mr. Dukszta:** The second point is: You were involved in the McKinsey report, Dr. Durost?

**Dr. Durost:** In the same sense that the staff at Lakeshore and the rest—

**Mr. Dukszta:** But you had some input in it?

**Dr. Durost:** We met regularly with the McKinsey consultants.

**Mr. Dukszta:** How regularly did you meet?

**Dr. Durost:** They were there, it seemed, at least once a week, they made presentations to various committees, they collected data, we discussed their initial takeoff, we disagreed at one point when they were starting to talk about working with diagnostic categories. We talked them out of that and they talked about chronic and acute and so on.

**Mr. Dukszta:** What you're saying, in fact, like Dr. Bond and others have said, is you've had a fairly significant input into the McKinsey report.

**Dr. Durost:** In the initial phases helping them to line up their—

**Mr. Dukszta:** In the data collecting.

**Dr. Durost:** In data collecting. We were not involved in their analysis and their development of recommendations.

**Mr. Dukszta:** If you were asked, surely you would have talked as you're talking now about the role differentiation between psychiatric units, type of patients, the need which the psychiatric patients have, did you not?

**Dr. Durost:** I don't recall having had an opportunity during the development of the report to make some of the comments—

**Mr. Dukszta:** How many hours did you spend talking either within a committee about the McKinsey report, or to the members of the McKinsey staff?

**Dr. Durost:** Thirteen.

**Mr. Dukszta:** Thirteen hours?

**Dr. Durost:** I haven't the slightest idea.

**Mr. Dukszta:** Well, you said once a week. How many hours once a week?

**Dr. Durost:** They did it in phases and they kept coming back to us and saying, "This is what we're proposing. What do you think?" and our group would comment on it.

**Mr. Dukszta:** And would you say yes or no, Dr. Durost?

**Dr. Durost:** We would say both.

**Mr. Dukszta:** But it doesn't seem to be that it's reflected in the report that it was a minority opinion. It seems like they have collected what seems like a general opinion of almost all the whole psychiatric body, the experts, the professionals, and they then put it into a report. Am I not right?

**Dr. Durost:** They put it into a report that reflected the conclusions they drew from the input made by the staff at Lakeshore and Queen Street.

**Mr. Dukszta:** Right, okay. Then my next question—

**Dr. Durost:** Then they're of course responsible for the output.

**Mr. Dukszta:** Then when did you change your mind about the McKinsey report, Dr. Durost?

**Dr. Durost:** I did not suggest, I don't think, today that I have changed my mind about the McKinsey report. As medical director of Queen Street my life would obviously be very much easier and I would be spending a lot more time in my normal activities if the McKinsey report recommendations had been accepted.

**Mr. Dukszta:** Oh, well I'm sorry to say that Mr. Conway is not here to hear it, because he perceived curiously that there was a discrepancy, ambience differences between your presentation and Dr. Anderson's. What you're saying, in effect, is that in some sense you do agree with what the conclusions were in the McKinsey report, not quite as ardently as Dr. Anderson, but you are agreeing because it made your job easier, delivery of services easier, and it would be a more appropriate way of dealing with it. Am I not right?



Dr. Durost: That's correct.

Mr. Duksza: Thank you, Dr. Durost.

Mr. Chairman: Mr. McClellan?

Mr. McClellan: I'll try to be exquisitely brief. By way of pursuing the question of fire incidents that I had raised with Dr. Anderson, I wonder, Dr. Durost, if you could make available to the committee, as soon as it is convenient for you—how would I describe them?—I suppose fire incident reports with respect to the fire incidents that have taken place at Queen Street over the past 12 months. If you could submit that to the chairman at your convenience, because the issue of fire safety does keep occurring in these hearings, it would be useful to have a specific description of each of the incidents that occurred.

The second piece of information I would be grateful to obtain from you has to do with the numbers of staff at Queen Street. Do you have that data with you this afternoon?

Dr. Durost: I know that we have 811. My latest figure that I recall is a full-time complement of 811, and my understanding is that with the closure of Lakeshore there will be a transfer of, I think we requested, between 350 and 360 staff. The 811 figure includes the total staff of Queen Street, clinical and support services, whereas the figure from Lakeshore inevitably is heavily slanted towards the clinical side.

Mr. McClellan: Do you have a breakdown of your new staff total of 1,171? What would the breakdown of that be between clinical and support? If you don't have that with you, perhaps you could obtain it for the committee.

Dr. Durost: I would have to get that.

Mr. McClellan: And that's for a bed setup of 530?

Dr. Durost: Ultimately either 600 or 632.

Mr. McClellan: Okay, that's for a bed setup of 600.

Dr. Durost: Also, of course, one must take into consideration that this will include staff for the operation of our six satellite programs at Queen Street, plus the outpatient programs at Lakeshore.

Mr. McClellan: So you're saying that for 600 beds you will have 1,171 staff. Well, my question to you is very simple. The McKinsey recommendation for a bed setup of 595 is 1,987 staff.

Dr. Durost: One thousand—

Mr. McClellan: Nine hundred and eighty-seven. Oh, wait, sorry, I may be wrong.

Dr. Durost: It doesn't sound right.

Mr. McClellan: Yes. In fact, I am wrong. Okay, my apologies. I was reading that inaccurately. Are you satisfied that your staff complement is adequate to the number of inpatients in beds?

Dr. Durost: If you want to underline the word "adequate". I would agree with your statement. No self-respecting medical director would say that anything better than adequate one would like more in the direction of optimal—

Mr. McClellan: What's optimal?

Dr. Durost: —but I'm too realistic to expect anything of that kind. I don't know what's optimal. If there's one unresolved problem in the field, it is a definition of optimal staff-patient ratios. The variables are simply too complex for anyone to have resolved that issue.

Mr. McClellan: Thank you, Dr. Durost.

Mr. Chairman: Mr. Lawlor?

Mr. Lawlor: Doctor, you are a lovable man.

Dr. Durost: Thank you, Mr. Lawlor.

Mr. Lawlor: For that very reason you're somewhat difficult to contend with. Part of your lovability has to do with a certain sanguine disposition, if I may say so. The difference between you and Dr. Anderson is an honest difference of opinion as I see it, and whereas he uses the possibility—no one can look that deep into the future—the possibility of the disaster occurring in your hospital over the long term, your answer, as I wrote it down, was that it isn't necessarily an inevitable outcome. If you're wrong, sir, you have very great problems, to say the least, to contend with and there would be something of a retrospective regret, I would take it, having launched into the position. Let me just continue for a moment.

I was delighted to hear you say that in its basic tenor you affirm the McKinsey thing. My impression was, from your evidence, not quite that; that your position was predicated upon three different elements, any of which if proved questionable, or that the consequences proved not to come to fruition, again, could have very grave consequences indeed. One of them is an expansion of the general hospital with the capitalization and the very considerable cost in that particular context, over against the utilization of the present premises which are, on the evidence we have, available for another 20 years.

[3:45]



The second one was a co-ordination, a proper co-ordination of services. Generally in the third one, a much enriched community again. You see, I consider that somewhat quixotic, with respect, that these kinds of funds of which you're speaking as the alternative proposition and as the basis for the preconceptions, if I may put it that way, of your critique of the McKinsey report—all of this could take hours for us to analyse in terms of the cost picture over against the present retention of the hospital. My question then is: Do you agree with me that there are these working presuppositions in your position?

**Dr. Durost:** You're quite correct. I intended to reflect some of the comments that I share in Mr. Fisher's testimony of two days ago. I need to put this in perspective because it sounds as though I'm taking two positions at the same time. I believe I said that if the McKinsey report was implemented as submitted, my life as medical director at Queen Street would be eminently simpler and less chaotic than it is at the present time, and may well be in the future. However, I share Mr. Fisher's feeling that the McKinsey consulting firm had a very limited mandate, that its submission was not addressed to the system, and was not able to include recommendations or did not, in fact, include them, except as a kind of footnote about how things could be different if general hospital activity patterns changed, and if—et cetera, et cetera. My feeling is that—

**Mr. Lawlor:** I hate to interrupt, but that's not quite fair to the McKinsey report. As I read it, the report does make a discursive division between the role and function of the one type of hospital—the type of care, the type of patient—and the other, and the hospitals affirm that. What you're suggesting is a revolution.

**Dr. Durost:** What they are saying is that there is little or no likelihood, given the present circumstances, of any change in the status quo. My own personal feeling is that it's unacceptable. I don't think anyone should accept the status quo as a given; I think there should always be opportunity for change.

When I went into the field of psychiatry the per diem at Douglas Memorial Hospital was \$1.40. Consequently, in the time that I've been in the field of psychiatry there have been enormous changes and I simply am not of the disposition to accept a report that is based purely on a continuation of

the status quo, however comfortable that might be.

**Mr. Lawlor:** Without getting into the mere politics of the issue, there is a certain government around here that has been in power for a long time by maintaining certain aspects of the status quo. And unless we had firm indications of a change of heart, or of any disposition thereto, then your or my opinion on this matter really doesn't matter very much, does it?

**Dr. Durost:** I realize that this committee has a mandate to look at the issue of the closure of Lakeshore Psychiatric Hospital and the implications thereof, and presumably my comments about status quo and a feeling that there is room for change in the activity patterns of other components of the mental health system may be outside the jurisdiction of this committee, so they are gratuitous in that sense.

**Mr. Lawlor:** Well, they're not outside our private thoughts, you see. Nor yours.

**Dr. Durost:** Nor mine.

**Mr. Lawlor:** Just one other question—we have to get on. With respect to the special observation unit as it was at the Lakeshore hospital, have you had an opportunity to speak to Dr. Wayne about such a unit at your hospital? My understanding is that he is rather strongly in favour of it.

**Dr. Durost:** I discussed Dr. Frank's testimony with Dr. Wayne on my return to Queen Street Mental Health Centre. On a number of occasions, over the period of time Dr. Wayne was at Queen Street before I arrived, the issue had been raised as to whether or not Queen Street Mental Health Centre should have a closed unit for the management of temporarily disturbed patients. My own bias, without being able to defend it perhaps scientifically, is that I have been very reluctant to see the development of such a unit at Queen Street. Part of the reason has been that we've been trying to change the public's perception of Queen Street Mental Health Centre.

The existence of a closed unit, rightly or wrongly, in my view and in the view of a number of the staff, would be such that one would reify the idea that madness, badness and violence are somehow or other synonymous. We also have a 68-bed forensic unit at Queen Street and we will have 40 warrant-of-the-Lieutenant-Governor patients. To add a closed unit at Queen Street would, to my mind, create a disproportionate number of patients in this category. It would run the risk of creating a regressive movement in terms of the public's perception of what goes

on in a hospital like Queen Street, which we have been working extremely hard to change over the past 20 years—certainly for a long time before I came.

I am, however, in favour of some form of regional resource that might be shared by three or four Ontario hospitals for the temporary housing of people who are difficult to manage in the normal course of events with wards that are generally open. We've had good working relationships with Penetang, which has agreed to accept patients from us and with St. Thomas, with their unit for disturbed female patients. On two or three occasions Dr. Franks has been kind enough to take a patient from Queen Street to Lakeshore on a short-term temporary basis, to help out on a colleague-to-colleague basis.

**Mr. Kennedy:** Just how far east is your catchment area?

**Dr. Durost:** As far as Victoria Park.

**Mr. Kennedy:** Do you have any relationship with Whitby?

**Dr. Durost:** In the sense that our catchment area ends where Whitby's catchment area begins. But as I think has been said before, the general hospital units in Scarborough and that area tend to carry a large percentage of the work in that area, whereas Whitby tends to be a bit more oriented towards the east—Oshawa, et cetera.

**Mr. Kennedy:** Speaking of inpatients, you indicated that in the short term at least there's no overcrowding likely to occur. We're told there are some vacancies at Hamilton, and you've just mentioned the relationship with other hospitals—St. Thomas and Penetang. Do you see an overcrowding problem arising with Queen Street? Or is it part of an overall picture we must examine in terms of accommodation?

**Dr. Durost:** I think I've indicated the latter. I don't think it's possible to absolutely rule out the possibility that Queen Street will develop an overcrowding problem; but I'm optimistic enough to think that good working relationships with Penetang, St. Thomas, the Clarke Institute, other facilities—plus a well-planned integrated community support system—will prevent that from happening.

**Mr. Kennedy:** I haven't refreshed my memory with the McKinsey report, but a rebuilt Whitby was in the recommendations. It would be expanded, I presume.

**Mr. R. F. Johnston:** It's the same size as it is now.

**Mr. Kennedy:** It's the same size, is it? Thank you.

Okay, I just wanted a clarification on that because you mentioned the short term and you explained how that does something for the long term. Thank you very much, Dr. Durost.

**Mr. Leluk:** Dr. Durost, I apologize that I wasn't here earlier when you began your statements. If I ask any questions that might have been asked, just tell me they've been asked or pass them by. But I do have some questions I wanted to put to you. We had Dr. Jerry Cooper of York-Finch General Hospital before the committee yesterday, and he indicated to me, after a question I posed to him, that the size of a psychiatric hospital facility would have some negative effects on the quality of care that could be provided.

It has been said that the projections for Queen Street are possibly 600-plus beds. Do you see the size of a hospital facility having any negative effects on the quality of care that might be provided in such a hospital?

**Mr. Chairman:** We have gone over that, Mr. Leluk, at considerable length.

**Mr. Leluk:** All right, I will pass that by.

Concern was also expressed regarding the accessibility of the Queen Street Mental Health Centre. Was that question raised?

**Mr. Chairman:** We have gone over that too.

**Mr. Leluk:** Dr. Cooper pointed out yesterday to this committee that general hospitals were reluctant to deal with the Queen Street Mental Health Centre. Was that discussed at all?

**Mr. Chairman:** Yes, it was.

**Mr. Leluk:** It would seem that everything has been covered. I am not going to pursue it any further. Thank you.

**Mr. Chairman:** Thank you very much, Dr. Durost. We appreciate your attendance. We hope it has not been too onerous for a lovable man.

**Mr. McClellan:** I would like to remind Dr. Durost—if he could provide those fire incident reports as well as a breakdown of his staff between clinical and support.

**Dr. Durost:** Yes.

**Dr. Munroe:** Mr. Chairman, would it be in order for me to make a very brief comment, just touching on one or two of the points that have just been made?

**Mr. Chairman:** By all means.

**Dr. Munroe:** First of all, I am the psychiatrist in chief at Toronto General Hospital, so I am from the ivory tower.

One of the things I think it is very important to point out is that because there is



such a lot of concentration at the moment on Lakeshore, there is a very artificial distinction being made between general hospitals and psychiatric hospitals. There are obviously a lot of differences, but in a general hospital, in practice, we could deal with virtually all types of psychiatric problems other than the very severely anti-social patient, the patient who is potentially very violent. But in a general hospital unit which depends on using its small number of beds in a very high turnover fashion we are very vulnerable to silting up, and that is where the psychiatric hospitals have enormous value. They have a larger number of beds and the utilization of these beds can be at a somewhat slower rate.

We are nonselective in Toronto General Hospital and we admit about 700 acute cases a year. The interesting thing is that although we are nonselective, year by year our population remains different from the population of Queen Street and also very different from the population of the Clarke Institute. If one looks at the statistics one finds that the Clarke Institute's population is rather like that of Queen Street demographically, but the general hospital units are rather different in terms of sex distribution, age, diagnostic distribution and so on.

**Mr. Duksza:** And class.

**Dr. Munroe:** That is right.

The point perhaps that I would like to make here is the admission policies to hospitals appear to be determined within the hospitals. In fact they are not; they are determined by extrahospital influences. It is where the patient gets to that determines the population of the particular hospital. We do not have control over that; it is influenced by police, ambulance, where patients prefer, where doctors refer and so on. That kind of influence is I think extremely strong.

If I may show one bias in finishing what I would like to say here, I am also an internist as far as my British training is concerned, so I have a very strong bias towards the integration of psychiatry with medicine. The main criticism I had when I saw the draft form of the McKinsey report was that it continued to emphasize the separation of psychiatry from the rest of medicine. I think this is something that has not been brought out, at least in the testimony I have been listening to in the past day or so.

In the general hospitals this is one of the main strengths we have. Between a quarter and a half of the patients I see or that are dealt with in my unit, have some significant medical problem or need some significant kind of input from a physician, or surgeon,

or another specialist. This is the kind of particular facility we can offer which I think a psychiatric hospital cannot offer.

Even more important than that is the fact that because we are in a general hospital setting we remain integrated with the rest of medicine. I think psychiatry has suffered probably more in the last century from being so cut off from the rest of medicine.

Thank you for allowing me to make that point.

[4:00]

**Mr. Conway:** Just one or two general questions. In the context of what you've said, can you indicate, given the state of institutional and noninstitutional psychiatric services in the Metropolitan Toronto area at this point in time, whether or not you can live with some degree of professional comfort with the ministry's intention to close Lakeshore as of September 1, and create a much larger institution at Queen Street?

**Dr. Munroe:** If you were to ask me, "Is it going to have much effect on the functioning of the psychiatric unit at Toronto General?" it's not, but that's because we're not dealing with the same catchment area. And I think perhaps the closing of Lakeshore can be seen as part of a process that's been going on for a very long time. I wouldn't quarrel with the process necessarily; I would quarrel with the timing perhaps. I think the timing is injudicious.

**Mr. Conway:** In what way is the timing injudicious?

**Dr. Munroe:** Dr. Wasylenki was asked yesterday how long it would take to set up adequate outpatient facilities given any sum of money, and he talked in terms of a year or two. There have been recent reports about the situation in Britain, where as you probably know there's a very integrated social services setup, and where there's been a tremendous amount of emphasis, since the 1959 Mental Health Act, on setting up community facilities, outpatient facilities, and so on. I think of all the authorities in England, only one has come anywhere within its target of setting up community facilities and outpatient facilities, and that happens to be in a very rural area. None of the cities has ever got anywhere near it.

So I don't think we're talking in terms of a year or two; I think we're talking in terms of five years, ten years, to set up the kind of replacement facilities that are needed.

**Mr. Conway:** Is it a reasonable conclusion to suggest that in the absence of those adequately supported community-based mental



health services, and notwithstanding the process of deinstitutionalization, that as a bare minimum the Lakeshore facility should be kept open until alternative community services are available?

**Dr. Munroe:** That's the problem I have. I think it's going in the wrong sequence. If you could show that the community facilities or the other hospital facilities were growing a little ahead of the one down at Lakeshore, nobody would quarrel with that, but I think it's going the other way.

**Mr. Conway:** So it's a very legitimate quarrel to suggest that the hospital should not be closed until at least there is some more tangible evidence the community resources are strengthened and in place.

**Dr. Munroe:** That would be my view, yes.

**Mr. R. F. Johnston:** On the British example, which I was going to raise earlier, but I didn't want to keep the last witness too long on community services. How long have they had this integrated system?

**Dr. Munroe:** The integrated system for the social services has existed for about the past six or seven years. But the Mental Health Act of 1959 sets out the guidelines that were to be followed in setting up community resources.

**Mr. McClellan:** This is part of the Seeborn study—

**Dr. Munroe:** It's not just the delivery system, but the profession of social work was completely restructured.

**Mr. R. F. Johnston:** And even while this has been going on, I recently saw a study done in Scotland about the community care approach—I can't remember the name of the study but it basically was showing a number of inadequacies—it was done two years ago, on what had been put in place up to that time. The latest things I've been reading from Britain have in fact been articles on the problems of under-institutionalization. At the same time the community service network has not been providing the necessary backup. Would you have any comments about that?

**Dr. Munroe:** You mean lack of beds, lack of—Well, that's a very relative thing. I think there always is a lack of beds, but I think beds are a very badly used resource. It's a difficult thing to argue, because you can show from region to region in any country the same number of beds in roughly the same circumstances are used totally differently. I think studies like that tend to look at a here-and-now situation and don't em-

phasize a management situation. I wouldn't really like to comment beyond that.

**Mr. R. F. Johnston:** One of the main premises of the argument I've seen, that there is under-institutionalization or whatever, has been that because Britain did not go to the expansive building of institutions like homes for the aged or whatever, during the same period as North America, especially as we did in Canada, they were left in the position of not having adequate backup and I see a tie-in with closing Lakeshore before you have the backup of community services.

**Dr. Munroe:** I'm sorry, I'm with you now. If you look at the statistics between England and Ontario, you find that Ontario has a tiny mental health problem because it's only got somewhere between a third and a half the number of psychiatric hospital beds, and we're not talking about general hospital unit beds. That's because of the process you've been describing, of opening up long-stay beds in the communities rather than in the hospitals. You're quite right; Britain hasn't gone for that in a big way. And is suffering from this because the patients are still stuck in the psychiatric hospitals.

**Mr. R. F. Johnston:** In the area of community services in Toronto at the moment, I started to ask the previous witnesses this and he gave an example of one group that was well used, in terms of co-ordination, and alluded to the fact that there were others that were not. I am thinking of a lot of the short-term grants that have been given out by Health over the last four or five years, especially. Would you concur with that? Are there any examples you would like to give of areas with lack of focus?

**Dr. Munroe:** If I could really only comment very generally, Dr. Durost commented on Community Resources Consultants, whom we find invaluable. If I can compare the setting here in Toronto with the setting in Liverpool, where I came from, which is a very poor, very broken-down city, very different from Toronto, the community resources seem to me to be in many ways excellent, but very poorly co-ordinated.

Community Resources Consultants have been extremely useful to us. We have a very short-term assessment-treatment-disposition policy, and if we were to fish around ourselves for the kind of resources we're looking for, our length of stay figures would be very significantly lengthened and by being able to plug into something like CRC, which cuts across a whole range of facilities,

our turnover is increased very materially indeed.

**Mr. Kennedy:** In your experience in Canada and in Ontario, Dr. Munroe, how does Ontario stand up in the provision of psychiatric care, generally?

**Dr. Munroe:** In terms of what an individual patient can expect? I think it stands up extremely well, compared with, let's say, the United Kingdom. But again, and this is following on what Dr. Durost said, the co-ordination of health care tends to be lagging behind the quality of care.

This is something that we in the teaching hospital group are now beginning to address. If you look at the general hospitals—for example, like the Toronto General Hospital—one of the criticisms that has been made is that we're all rather competing against each other and doing rather similar things. And psychiatry isn't just standing still; psychiatry is dividing up into a whole lot of subspecialties. We're now very actively and consciously beginning to look at our different functions and to see how we can co-ordinate better so that an individual patient can be placed in a setting that's best designed for his treatment.

This is something that needs to be emphasized. With the kind of facilities that we have here in Toronto, certainly in downtown Toronto, we're extremely well placed to build up a very comprehensive type of service for the psychiatric patient.

**Mr. Kennedy:** Which is the direction in which we should be going. And in your view we're moving there, but you suggest we step it up a bit?

**Dr. Munroe:** I think it should be stepped up, and I think, if I may say so, with respect to the Lakeshore closure maybe you're pulling a bit of a plug out. I don't know quite how to put it—it's just kind of throwing the thing out of sync at the moment, I think.

**Mr. Duszta:** I think it's called a disaster.

**Dr. Munroe:** No, I wouldn't say it was a disaster, but I think that it is throwing the process out of synchronization.

**Mr. Kennedy:** The process was, as I understand it, designed or the planning started 10 years ago at Queen Street, and the previous doctor indicated that he'd rather have a 300-bed hospital than one with 600 or 630 beds. Do you think 600 is too big?

**Dr. Munroe:** If it was a monolith, yes. But it's not. As Dr. Durost pointed out, it's really four mini-hospitals, and that, I think, is acceptable. I don't think there is a magic number but it is certainly true that you can

lose a patient much more easily amongst 150 other patients than amongst, say, 40 other patients, as we would have in the general hospital unit.

**Mr. Kennedy:** Do you think there is a greater potential—and this has been touched on too—for increasing the outpatient services?

**Dr. Munroe:** Oh, for sure.

**Mr. Kennedy:** There is a great—Excuse me, just let me have a look at that.

**Dr. Munroe:** The figure is disguised here because of the number of patients who aren't in psychiatric hospitals. In fact, if you took all the patients who are in beds anywhere and compared them with the patients in any other kind of speciality beds, psychiatric patients would make up about 45 to 50 per cent of the total. Now, the turnover of a lot of these patients is slow so it's not psychiatric patients who make up half the total of medical problems, but they make up probably about 30 per cent of a family or general practitioner's caseload, and you can increase that number according to your definition. If you look at the resources allocated to psychiatry and those allocated to the rest of medicine, the discrepancy is enormous. The allocation to psychiatry is just waiting to be upgraded and desperately needs to be upgraded. It's a totally open-ended situation, as Dr. Durost indicated.

**Mr. Kennedy:** So there's a category of patients that can't be dealt with in a general hospital, or, indeed, in the community. We need them both.

**Dr. Munroe:** And, for the time being, the psychiatric hospital. The system should be—

**Mr. Kennedy:** Interwoven, integrated.

**Dr. Munroe:** —should be interwoven, yes.

**Mr. Kennedy:** Thank you very much, Dr. Munroe.

**Mr. Chairman:** Thank you very much, Dr. Munroe. Good luck at Toronto General.

**Dr. Munroe:** Thank you very much.

**Mr. Chairman:** Our next witness is Dr. Rzakdi, the chief of psychiatry at the Etobicoke General Hospital; and I believe, doctor, you are reporting on Mayor Flynn's task force.

**Dr. Rzakdi:** Yes, that's right.

**Mr. Chairman:** Do you have an opening statement, doctor?

**Dr. Rzakdi:** Yes, I'd like to make a preface to my brief report. I just intend to highlight the report and you could read it at your leisure. It's not very long.

I would like to preface my comments though by saying that the closing of a mental



health service, or of mental health services, to somebody working in the field at the grass roots level, always engenders a great deal of anxiety and apprehension about exactly what the closing means. We have learned since that the closing isn't really a closing, but dislocation and perhaps relocation. The impact of that on the users of the service and the people who refer to it obviously has to be looked at. That was the purpose of the mayor's task force—to look at the impact the closing of Lakeshore had and is having.

Essentially we have looked at two aspects: the closing of the inpatient services and the closing of the outpatient services. We have learned that the outpatient services are not being closed; they will be continued uninterrupted, but they will perhaps be relocated.

As far as the inpatient services go, they cause a great deal of concern to a number of people. We feel that the closing of services will be costly, will cause dislocation and added apprehension among the users. I'd just like to elaborate briefly on that.

Over the years the general hospitals in the borough of Etobicoke have established a working relationship with Lakeshore which has been very useful to the patients of Etobicoke, as well as the referring hospitals. The policy of the Lakeshore Psychiatric Hospital to admit those patients who have come to us in emergencies when we could not provide them with beds has been a great advantage. The information that we have about Queen Street's functioning in this area leaves us with some apprehension, although personally our own hospital has not had much to do with Queen Street.

[4:15]

I would like to make some comments on something that Dr. Durost said, and with all respect to Dr. Durost. He talked about the transferring of patients from the inpatient of a psychiatric unit to the hospital at Queen Street. The committee structure which has developed over the years to monitor that kind of transfer is not something that is objectionable. However, in the admission of a patient from the emergency department of a psychiatric unit, an emergency department of a hospital, at 11 o'clock at night, if we are not guaranteed an admission at that time then there may be some grave consequences. That's the kind of concern that has arisen as a result of the proposed closing of inpatient services at Lakeshore.

Other factors which have been mentioned in our survey of opinion from the borough is the concern that the public health nurses, the police officers and referring agencies have.

They have a concern that the increased costs involved will be something to look at. There will be increased time, there will be problems of transportation, and there will be increased man hours of work involved in transferring patients from Etobicoke to the Queen Street Mental Health Centre.

A possible solution endorsed by the task force is that services should remain on the Lakeshore grounds—and I understand that there is some attempt to keep the alcoholic unit at Lakeshore with the inpatient services associated with it there. That's encouraging, but it may not meet the future needs of inpatient services in that area.

The second part of my report has to do with outpatient services, and the mayor's task force has endorsed completely the report of a subcommittee on outpatient services in the borough. One of the good things that has happened since the announced closure of the Lakeshore is that it has allowed people to have another look at what services are being provided and what services need to be provided. Working in the field, one always has the feeling that not enough services are provided, and so this is a good opportunity to look at what's needed and how to meet those needs.

The outpatient subcommittee has proposed, and we endorse, the idea that the current outpatient facilities provided by Lakeshore be continued. Over 60 per cent of all the services delivered from the Lakeshore Psychiatric Hospital are directed at Etobicoke patients, and so it is very important for our patients in Etobicoke to continue to have those services provided within a reasonable distance. We support the idea that the only place available in the Etobicoke area, because of the bylaws and what-have-you, is probably the Lakeshore land itself. And even though there are 64 acres there, it wouldn't be necessary to use all the 64 acres; only some of that acreage would be used to maintain the existing services, and that would be part of our proposal.

The other important aspect of the outpatient subcommittee's report is the proposal that an interagency or mental health council be formed to continue to monitor the mental health needs of people in Etobicoke, and further details of that are contained within this report.

I'll stop there and if there are any questions I'd be glad to try to answer them.

**Mr. Conway:** Just looking very briefly over the first part of your report of inpatient services, I want to clearly understand that the recommendation calls for the mainte-



nance of inpatient services for the long term at the present Lakeshore facility, really not unlike what Mr. Lawlor has suggested on previous occasions, perhaps on a much scaled-down version of what is presently there; a smaller unit, but a unit nonetheless.

**Dr. Rzakdi:** Yes, right, primarily to serve the population of Etobicoke, but I am sure it could also serve some of the needs of the Peel area.

**Mr. Conway:** There is no question in your mind professionally that the need exists now and will continue to exist over the next period of years.

**Dr. Rzakdi:** Yes, if I could just elaborate on that. Reading the McKinsey report, I was surprised to learn that my hospital, which is a general hospital psychiatric unit, is not dealing with difficult patients—that was the implication. I never talked to anyone from the McKinsey group, but had they come and looked at the services they would have seen that we try to provide a broad range of services to all kinds of problems.

If I may talk about my own hospital, I think in a year we may have to refer 15 patients to Lakeshore Psychiatric Hospital, which is not a lot when you consider we admit about 700 people a year. But when we need to admit them, we need to admit them—not because we don't have beds or they are too violent, or they are beyond the capacity of our staff and our facilities. So I differ with the McKinsey report in that regard. I think there is a change occurring. I think general hospitals are tending to deal with the broad range of psychiatric disorders, and not just the easier cases.

The implication is that general hospital units deal with easier patients whereas the psychiatric hospitals deal with the more difficult ones. That's true, and I think that in this sense we will always require the backup of a hospital like Lakeshore Psychiatric Hospital or Queen Street Mental Health Centre to provide the ongoing, long-term type of treatment that can never be provided in a general hospital.

**Mr. Conway:** The hospital you work at is one that is very central to the catchment area involved. Am I correct in that? one that is very central to the catchment

**Dr. Rzakdi:** It's pretty central, yes.

**Mr. Conway:** Central in terms of the overall implication of—

**Dr. Rzakdi:** It's North Etobicoke, yes.

**Mr. Conway:** That's right. From what you can see at this point in time, the procedure to phase Lakeshore out completely by Sep-

tember 1, would then, for facilities like yours, create serious and wide-ranging chaos of a sort.

**Dr. Rzakdi:** Well, not chaos; certainly concern. Admission policies or admission procedures are somewhat different at Queen Street than at Lakeshore Psychiatric Hospital. If there isn't some accommodation to the needs of the general hospital units we foresee having to deal with more violent and potentially more difficult patients. I think we foresee that there would be more misadventure in our units; there'd be more violence; more aggressiveness. And I underline Dr. Durost's statement that he doesn't want an acute-care unit in his hospital because it would not promote goodwill and would not diminish the negative feelings of the community about psychiatric patients. All the more reason why this should not occur in general hospitals for the same reasons. If you have highly disturbed, dangerous types of patients wandering around in a psychiatric general hospital unit, the more difficulty you have trying to get the community to accept the problem.

**Mr. Conway:** The mayor's task force on mental health concurs essentially with the recommendation of McKinsey that the facility at Lakeshore should be maintained and rebuilt, renovated, or whatever. But the major inpatient facility should continue there. Unfortunately I have not had the opportunity to read the brief entirely, but can you indicate to us exactly what the task force has in mind to the degree that it gave specific consideration to the sort of physical plant it would like to see developed at Lakeshore campus? And considering also that this committee has heard testimony from at least one earlier expert witness who indicated that economies of scale and good psychiatric medicine dictates in favour of hospitals with 150 to 300 beds—I think it was referred to at that time as an optimal—can you give us any idea of the sketch that the mayor's task force has for the sort of facility that we should be looking at at Lakeshore?

**Dr. Rzakdi:** Well, we really did not attend ourselves to that. In forming the committee the mayor was primarily concerned with obtaining information about the impact that the closing would have. The feeling is that some services contained on the site would be useful to the people of Etobicoke. We did not go into the details of that or what kind of facility, or how big, or anything like that.

**Mr. Conway:** By some services I presume you mean a range of services roughly parallel to that range presently in place at Lakeshore.

Or are you envisioning something substantially different and perhaps substantially more specialized?

**Dr. Rzadki:** No, I'm not envisioning anything specialized. I agree with the general feeling that there is a diminishing need for psychiatric hospitals like Lakeshore Psychiatric and Queen Street Mental Health Centre. That's largely due to the treatment that's occurred over the last 20 to 28 years or so.

It's hard to know where this trend will bottom out, as has been mentioned before, so I'm not sure what the size should be or what the needs will be. I'm not really cognizant of the population demands. I understand that Etobicoke is a growing area; so is Peel. Perhaps this indicates that there will be more patients in that area, but what the need will be for the kinds of services provided, particularly by psychiatric hospitals, is really not clear to me except that we know they're needed now.

**Mr. Conway:** Well, I want to be clear on my last point. To close Lakeshore on or before September 1, to move that patient load and the catchment area over to Queen Street would, given present conditions there with respect to tradition and the current state of community mental health services, create considerable dislocation. Am I correct in that from where you view the situation?

**Dr. Rzadki:** It's anticipated by the people we surveyed that there would be considerable problems. They've already been mentioned. Those are problems of transportation, increased costs in having to transport people, and the fact that services would no longer be provided within the community location for patients living in Etobicoke. There would be a dislocation of miles and consequent difficulties associated with that, the inconvenience. On top of that is the concern that the psychiatric units in general hospitals have, that the ready access to hospitalization may not be available. It means we would have to somehow cope and with the limited facilities that exist now, that's not a very pleasant thought. Does that answer your question?

**Mr. Conway:** Did the mayor's task force on mental health in Etobicoke give any consideration to the sorts of housing policies that would be required in the borough to deal with the principal recommendation for the continuation of inpatient services at a new or renovated Lakeshore Psychiatric Hospital?

**Dr. Rzadki:** Not in any great detail. I could make the comment that with the bylaws as they are in Etobicoke, group homes would have a difficult time being located, except in the Lakeshore area and except on the land

that's already available where the present Lakeshore Psychiatric Hospital exists. I think that land could conveniently be redeveloped to provide appropriate housing, boarding homes, as well as inpatient and outpatient services.

**Mr. Conway:** Is it your impression that there is sufficient flexibility in the Etobicoke community to consider making the sorts of bylaw changes that might be required to deal with new housing policies if we were to accept some of the recommendations?

**Dr. Rzadki:** I don't think I can answer that.

**Mr. Conway:** Thank you very much.

**Mr. Chairman:** Mr. McClellan?

**Mr. McClellan:** Could you tell us who was on the mayor's task force?

**Dr. Rzadki:** Yes, I was the chairman. Also on the committee was Mrs. Ollwyn Butchart, who is somewhere behind me, from the public health department; Dorothy McLean, representing Etobicoke mental health; Heather Thompson, police constable; Mrs. Avicen Flaherty, representing the Etobicoke Social Planning Council; and Mr. Gregory Dick for the planning department of the borough. I don't think I've left anybody out.

**Mr. McClellan:** There was no one from council on the task force?

**Dr. Rzadki:** Oh, sorry, Nora Pownall. How could I leave her out?

**Mr. McClellan:** I just wanted to focus briefly on your recommendations with respect to outpatient services. First, I wonder if there isn't an omission in the body of the text. You mentioned on page five of your brief seven existing Lakeshore psychiatric hospital programs serving Etobicoke and state that you want them to be continued. You leave out the behaviour therapy clinic, I think, which shows up on the chart—

**Dr. Rzadki:** Yes, right.

**Mr. McClellan:** —in the appendix. Is it safe to assume that you want the behaviour therapy clinic to continue?

**Dr. Rzadki:** Yes, oh sure. Oh, yes. The eight services on the chart are the existing ones and the ones we feel should continue.

**Mr. McClellan:** So I take it there was an inadvertent omission on page six?

**Dr. Rzadki:** Yes, probably.

**Mr. McClellan:** How much detail planning did you do with respect to your recommendations around the eight existing programs? Did you go so far as to cost them and to work out what kinds of physical



facilities would be available, what kinds of support staff requirements there would be and that kind of thing?

**Dr. Rzadki:** Let me clarify that this recommendation is endorsed by the mayor's task force. We did not put it together. It was put together by the community subgroup on outpatient services and I believe there are some costs available. We left them out. We felt that costs are something that should be worked out with the people who know how to do that. We didn't have the expertise to cost them out, although we had some rough figures. I think that report has been submitted to the regional meeting that was held in Etobicoke and was chaired by Mr. Skorcz, and I believe that submission does have costs involved.

**Mr. McClellan:** Taking into account the very tentative nature of the costs, could you share them with us even if they all are ballpark figures?

**Dr. Rzadki:** Well, I don't have—

**Mr. McClellan:** What I was asking about is the cost of existing outpatient services.

**Dr. Rzadki:** Mrs. Ollwyn Butchart has just joined me and she could tell you about the costs.

**Mrs. Butchart:** The community service and outpatient service costs roughly \$330,000; that's for 60 per cent. DARE total cost is \$291,580. The alcoholic unit is now called the addiction service unit and it is approximately \$614,816, plus the detox unit, and we haven't got a cost on that.

**Mr. McClellan:** That's the inpatient facility, is it?

**Mrs. Butchart:** It's for detoxification.

**Mr. McClellan:** Right.

**Mrs. Butchart:** They'd be in for two or three days.

**Mr. McLellan:** Right.

**Mrs. Butchart:** Speech therapists, one staff, approximately \$24,416. Geriatric outpatient, two staff, approximately \$34,000. Outpatient pharmacy, approximately \$20,000. The sheltered workshop we haven't got figures on yet. Behaviour therapy, \$128,717. Now these figures were obtained from the Ministry of Health, from Betty Jean MacDonald in programming.

**Mr. McClellan:** Right, and what's the grand total for that group?

**Mrs. Butchart:** We didn't actually figure out the total because we were assured that these come within the funding of Lakeshore Psychiatric. The cost is \$1.6 million for the services that already exist and the outpa-

tient service and we were assured we didn't have to worry about those when we were planning outpatient services.

Now, over on the new programs—

**Mr. McClellan:** Just to clarify, the ministry gave you the figure of \$1.6 million with the breakdown?

**Mrs. Butchart:** Yes.

Now, under new programs the salary of the co-ordinator, we estimate would be \$40,000, with operating expenses of \$35,000. The ministry tells us this is high.

Program developers, two staff; their salaries would be \$24,000 each, and we are asking for money so they can implement some programming because we want them to concentrate on housing, and we were suggesting \$60,000.

The purchase of service from agencies is approximately \$20 per hour, and it is going up when the budgets are set this year. We have asked for \$25,000 for that.

The original day-care cost would have included moneys to expand the geriatric program because at the present time there are only two workers to work with a number of patients and we have a waiting list. So we asked for more money there, but we now understand that West Park Hospital is implementing a plan and we said we would drop our expansion if we could be included in their plan. So we haven't a figure on that.

The crisis centre, approximately \$56,920.

The West End Club budget right now is \$7,500. We are asking to increase that to two to three nights a week and because right now they use volunteer services of the participating agencies, professional staff, we have to purchase service there and the budget would go up to \$55,000.

The Opportunity for Advancement have asked for \$37,000; and Friends and Advocates have asked for \$27,556; and I believe there is a proposal which would be included in our outpatients which is for day care for Etobicoke General, and I think that is around \$56,000.

**Mr. McClellan:** Do you have a big round number at the end of all of that?

**Mrs. Butchart:** Our new programs come to around \$300,000, approximately.

**Mr. R. F. Johnston:** New and expanded?

**Mrs. Butchart:** New, just new. We have not included any of the existing programs.

**Mr. McClellan:** When you were working out the budget, were you working within the constraints of the \$1.6 million or—

**Mrs. Butchart:** We were working in the constraints of \$1.3 million; \$1.6 million is for



the outpatient services, \$1.3 million is what they should save when they close the facilities and that is to be shared with Peel, North York, Etobicoke and the city.

**Mr. McClellan:** Thank you very much. I gather from your earlier remarks that you didn't work out a detailed model of what the inpatient operation would look like, let alone a budget?

**Dr. Rzakdi:** No. Our function was primarily to get opinions from people who would be affected by it, and we didn't go into any great detail, but we think that the co-ordinator, if that is approved, could certainly function with a committee to look at the costs seriously. In the meantime, of course, the system would be run by Queen Street Mental Health Centre, as it appears anyway.

**Mr. McClellan:** Right. Over a transition period?

**Dr. Rzakdi:** Over a transition period.

**Mr. McClellan:** Finally, I understand the thrust of what you are saying—and correct me if I am wrong—is that the inpatient and the outpatient services are an integrated system as you are proposing it?

**Dr. Rzakdi:** Well, they certainly are in the psychiatric units of general hospitals. What should be pointed out is that Lakeshore Psychiatric Hospital not only provides those special backup services to the general hospital psychiatric units, but it also provides very important local service to people living in the Lakeshore area, just the same as a general hospital psychiatric unit would provide service to people living around its location. Those are important, I think, to underline.

**Mr. McClellan:** So you want an inpatient facility as a backup for the range of outpatient programs that you are proposing.

**Dr. Rzakdi:** That seems to be the consensus among those we surveyed.

**Mr. Lawlor:** On page two of your brief, paragraph five, it says, "The medical officer of health for the city of Toronto indicates that Queen Street will not be able to meet the total demands of the two catchment areas, and as such, Queen Street should remain at its present size rather than reverting to a facility of 900 or more beds."

Have you any figures of your own with respect to this, or are these projections taken directly from the McKinsey report?

**Dr. Rzakdi:** I am not sure. This was taken from a letter that he sent to us. We asked him for an opinion about what impact he thought the closing of Lakeshore Psychiatric Hospital would have, and that was his re-

sponse. We included it as a sample of opinion. As I mentioned in my preface, when you close a service it engenders all kinds of apprehension and concern. I guess one of the concerns outlined by the medical officer of health of Metro is, would Queen Street be able to handle the extra load, and I think we have heard comments about that.

**Mr. Lawlor:** Have you got a copy of that letter?

**Dr. Rzakdi:** I think I do in here.

**Mr. Lawlor:** Mr. Chairman, I would ask that a copy of that letter be submitted for our records and for our perusal.

**Dr. Rzakdi:** I should say that this is a preliminary report. We are coming out with a more extensive one commenting on the actual letters that we receive. So there will be a more extensive report coming in a couple of weeks or so.

**Mr. Lawlor:** Again, I would request that you forward a copy to the chairman or the clerk of this committee, which can then be disseminated among the members of the committee. How soon do you expect that?

**Dr. Rzakdi:** Hopefully in two weeks or so, two and a half weeks perhaps.

**Mr. Lawlor:** Before too long, because cats tend to get out of bags, you know.

At the bottom of that page you talk about the 64 acres and the 22 buildings et cetera and "to continue to provide both inpatient and outpatient services at this location it is felt that consideration should be given to reducing the size of the site and the number of buildings, the benefits et cetera would be as follows."

I am fairly in accord with that and have said so. I don't wish to be unduly egotistical about it, but are you aware of my proposals with respect to a phasing operation for new buildings over a period of years, at a reduced-sized hospital, and the saving in capitalization that would be involved to the ministry, should they have a change of heart and be disposed to listen to reason, namely to me?

**Dr. Rzakdi:** Mr. Lawlor, I think that one opinion we didn't survey was yours.

**Mr. Lawlor:** Hmm?

**Dr. Rzakdi:** We didn't survey your opinion, honestly.

**Mr. Lawlor:** Oh, you haven't seen it yet, eh?

**Dr. Rzakdi:** No.

**Mr. Lawlor:** Oh, I have been talking from the rooftops. All right. I'll send you—

**Dr. Rzakdi:** We'd be very pleased to receive it.

**Mr. Lawlor:** We have a question on the Order Paper—

**Mr. Conway:** What is it about a poet in his own land?

**Mr. Lawlor:** —precisely on this particular point.

With respect to page six, you mentioned the retention of a number of five and six, to be continued in present premises or to be situated in suitable location. Has your task force found numerous, munificent, suitable locations?

**Dr. Rzakdi:** No.

**Mr. Lawlor:** That's what I thought.

In other words, you have a list of seven different facilities, some of which are going to be retained. The ministry has found itself in a logjam and has taken up balancing the addiction services unit—the detox is to be retained. I notice in your list, though, no mention of social orientation unit. This is for the mentally handicapped who suffer from those disturbances. That should be included too, I would take it. Would you agree?

[4:45]

And what you are saying, in effect, is that you use the words "after-care" but you mean, I trust, the range of outpatient services at present. Would you agree too that over against having to find hypothetical non-existent locations in the Lakeshore, it would be a saving to the ministry and to all concerned to retain these present outpatient services on the premises?

**Dr. Rzakdi:** You will remember I am a doctor and not an economist. That statement has been made by several doctors preceding me. I can't comment on that, but from my understanding of the situation in Etobicoke I would think there could be some saving there, but that is information given to me.

**Mr. Lawlor:** I mean, you don't have to be a psychiatrist to have common sense, do you?

**Mr. Conway:** Nor a politician, I should hope, Mr. Lawlor.

**Mr. Lawlor:** So I would take it that you would retain the intermediate care rehabilitation unit, the self-care unit, the occupational therapy, the vocational-recreational therapy and the outpatient community services, right on those premises, and would so advocate. Is that so?

**Dr. Rzakdi:** Yes, sure.

**Mr. R. F. Johnston:** Just three things. The reason this had to be done was because

of the crisis situation of trying to come to grips with it.

**Dr. Rzakdi:** Right.

**Mr. R. F. Johnston:** Essentially the status quo would have been fine as far as you were concerned.

**Dr. Rzakdi:** No, I think there is always the need to re-evaluate the kinds of services that are being delivered and I could comment on our own hospital that we were having 108 per cent occupancy of our 30 beds, so that we were coming to the point where an increase in beds was required just to provide more adequate service to the community surrounding us. Since we don't have a catchment area, that could be anywhere; whoever presents himself in the emergency department of a general hospital must be looked at and provided with a suitable service. Unfortunately we find ourselves in a position of not having enough beds, so we try to provide as much service as we can, but when we don't have a bed we often have looked to Lakeshore for a backup and have been provided with that backup. Before the closing of Lakeshore was announced, I think there was a need, certainly in the north end, for increased services, so—

**Mr. R. F. Johnston:** So therefore you already saw an increased need, not a decreased need, in your area.

**Dr. Rzakdi:** Sure, right.

**Mr. R. F. Johnston:** Are you aware of the report of the Social Planning Council of Metropolitan Toronto on suburbia in transition, or whatever the title is?

**Dr. Rzakdi:** I did glance at that.

**Mr. R. F. Johnston:** Some of the tenets of it would support what you are saying in the predicting sense, and that is that many of the problems of urban life in Toronto are now finding themselves out in the sub-urban areas which have not been as equipped to handle them, and it goes into a socio-economic analysis. Therefore the kinds of problems and intensity of needs of service that have been registered in the inner core of cities are now moving out to the sub-urban areas. Would you agree with that from your experience?

**Dr. Rzakdi:** Sure, I think I would.

**Mr. R. F. Johnston:** So that you would see an increase in need for services in your area in the area of mental health.

**Dr. Rzakdi:** Yes, I do.

**Mr. R. F. Johnston:** Did you have involved with you in your task force deliberations

the family service people, the family counsellors at all?

**Dr. Rzakdi:** Yes, they were represented on a subcommittee; we do have letters from them indicating their concern about the closing of Lakeshore.

**Mr. R. F. Johnston:** How does their concern run? Could you tell us?

**Dr. Rzakdi:** Since they deal with adults as well as children, primarily adults, primarily it has to do with the transfer of patients, the logistics involved in dealing with patients at a distance, the increased time that would be involved in the admission process and things like that, and with limited budgets. That presents quite a problem.

**Mr. R. F. Johnston:** Would they see an increase in their budget? Did they mention that to you?

**Dr. Rzakdi:** I think every agency that we surveyed saw some increase, a need for more money to live with the change.

**Mr. Leluk:** Mr. Chairman, I just have two or three short questions. Dr. Rzakdi, would you say Etobicoke's main concern is with respect to the outpatient programs as opposed to the inpatient services that are being provided?

**Dr. Rzakdi:** I think there was a double concern of both inpatient and outpatient services; certainly the outpatient concern was greater.

**Mr. Leluk:** The greatest concern would be with the outpatient services. In view of the testimony that Dr. Durost gave that Queen Street could admit the inpatients from Lakeshore Psychiatric Hospital, I don't believe you've been too specific with the type of inpatient facility you'd like to see remain at the Lakeshore site. Unless I missed that, did I hear you say something about a backup facility for outpatient programs? Would you elaborate on that?

**Dr. Rzakdi:** I'll just make some comments. The task force did not attend to the details of that kind of thought, but it would appear that to provide a comprehensive service to the citizens who live in Etobicoke who would be using that facility, one would consider a broad range of services that would include some inpatient services.

As far as the referring agencies using Lakeshore Psychiatric Hospital for their needs is concerned, and I can talk for my hospital in particular, our need is to have a backup service to handle those kinds of patients who are not suitably handled in a general-hospital type of unit. So Queen Street will be providing that for us and we look forward to trying

to work out some of the differences that have been talked about in terms of Queen Street's admission policies and those of Lakeshore.

**Mr. Leluk:** This was the next question I was going to ask you. I think, under section 3 and the concerns expressed in the inpatient services in the report, you talk about these differences in admission policies and this difference has raised sincere concerns on the part of psychiatric staff at both hospitals. Can you elaborate on what these differences are? Maybe this has come up earlier but I wasn't here earlier this afternoon and I'd like to hear your comments.

**Dr. Rzakdi:** I have no direct experience that I could comment on, only the experience that has been relayed to me by other users of Queen Street such as Dr. Cooper and Dr. Arndt, so I'd rather not. I'm sure you've already heard their concerns. The concern that we have is that perhaps our patients will not be admitted.

**Mr. Leluk:** Have there been problems of admission that you're aware of as far as your own hospital is concerned?

**Dr. Rzakdi:** Since our catchment area does not include Queen Street, we have not run into any problems with Queen Street. Once, a long time ago, I can recall one bad night when I couldn't get somebody admitted there but I got him into Lakeshore. That was quite a long time ago. So that's really a minor point.

**Mr. Leluk:** And would you be aware of whether the Queen Street Mental Health Centre has tried to do anything about the problems that have been mentioned by some of the witnesses who have appeared before this committee such as Dr. Cooper and others?

**Dr. Rzakdi:** Yes, I could report to you that at a meeting with Dr. Durost and other chiefs of psychiatric units we were greeted warmly and taken through the Queen Street Mental Health Centre. Our concerns were heard. I'm sure Dr. Durost is sincere in his efforts to try to cope with some of the problems we talked about.

**Mr. Leluk:** The last question I have is, do you feel that the \$1.3 million, which is to be committed to the new community-based programs the minister indicated in his news conference, will help to alleviate the pressures on the Queen Street Mental Health Centre?

**Dr. Rzakdi:** I'm not sure I follow that.

**Mr. Leluk:** The minister in his statement said \$1.3 million was going to be committed to beef up the community-based programs



and what I'm asking is, do you feel this would help to alleviate the pressures on the Queen Street Mental Health Centre?

**Dr. Rzakki:** I'm not sure. I think \$1.3 million could very easily be used to beef up deficient services that existed before the announced closing of Lakeshore. So I'm not sure whether that will have a great impact on reducing Queen Street's workload; I'm not sure about that.

**Mr. Chairman:** Thank you very much, Dr. Rzakki and Mrs. Butchard. Our next witness is Mr. Bateman, who is the Ontario fire marshal.

**Mr. Conway:** I'm wondering, Mr. Chairman, as our next two witnesses are fire people in that sense, whether or not, given the time, we could perhaps invite them both to the table as it were?

**Mr. Chairman:** Yes. We have as well Inspector Ross Taylor from the Etobicoke Fire Department and both are dealing, I presume, with essentially the same subject.

**Mr. Conway:** Very briefly, gentlemen, I'd like you to indicate for me if you can what your views are about the present condition of Lakeshore Psychiatric Hospital from the point of view of fire safety, keeping in mind the context of that sort of building, an 89-year-old structure, not unlike this marvelous old building in which some of us labour from day to day in the people's cause.

**Mr. Bateman:** If I might take the liberty of answering first, since I'll be briefer, I feel a bit of an impostor appearing here because I've never inspected the Lakeshore Psychiatric Hospital personally, or indeed any of our Ontario Hospitals. Our office has been involved in approving plans of renovations or expansions to these buildings and not too much has happened at Lakeshore. I have read fire reports from fire departments and the Ministry of Health, so I'll just give you my very general impression of Lakeshore.

One has to talk in terms of impressions rather than specifics in rating a building for fire safety. I would say it's fairly safe, certainly for a building of that vintage, for an institution of that age, and that it is no worse than the average in the province. That doesn't tell you very much, I realize, but intrinsically because of the relatively small size of the building, a relatively minimal amount of combustible construction, a certain amount of upgrading in fire alarms and fire escapes and so on that has gone on, I would say that it's a fairly safe institution.

**Inspector Taylor:** We believe it's as safe as it can be. Our initial step when investigators started to inspect the hospital was either to bring it up to a certain standard or not to use it. So we established some sort of a standard when we were going over Lakeshore and they have improved it quite a bit. They have continued to improve it until this day.

**Mr. Conway:** I assume from what you've just indicated that so long as the administration continued regular upkeep and paid attention to the standards that you have established, that facility could remain in use for at least a few years to come.

**Inspector Taylor:** I would say so. We had asked in the beginning for a number of things and one thing was updating the fire alarm system, which they did, and it's quite a sophisticated system. A few other things we'd asked for over the years were budgeted for this year. Perhaps since the closing they've discontinued this but they were prepared to do it.

[5:00]

**Mr. Conway:** So you see no real difficulty in continuing the use of that building so long as those kinds of standards continued to be met as they had been met there in the recent past.

**Mr. Bateman:** Right.

**Mr. Conway:** The reason, of course, for your appearance here today is that there was the general impression created, rightly or wrongly, in the minds of some politicians and I dare say certainly in the general community, that there was somewhere out there on this campus a real fire-trap that must be ended forthwith because we would all have on our consciences the spectre of some horrendous fire. That's the reason members of the committee have expressed a concern in having your testimony.

**Mr. Leluk:** I believe the statement was made that the buildings were as safe as they could be. Would that mean then that they would meet the current fire safety standards or, say, the fire code?

**Inspector Taylor:** The Ontario Building Code, the new one?

**Mr. Leluk:** Yes.

**Inspector Taylor:** No.

**Mr. Leluk:** They wouldn't?

**Inspector Taylor:** No.

**Mr. Conway:** Just a supplementary then. Maybe I can direct this to the fire marshal. Would this building meet that code?

**Mr. Bateman:** No.

**Mr. Leluk:** Just trying to solicit some information here, the committee has received a report of Mr. Manson of the Ministry of Health who is the fire preventive consultant. Has either one of you seen this report? If so, do you agree with this report?

**Mr. Bateman:** Yes, I've seen it in the last couple of weeks.

**Mr. Leluk:** Do you agree with it?

**Mr. Bateman:** Yes, I do. Yes, I think it's a good report.

**Mr. Leluk:** Mr. Taylor, do you agree with this report?

**Inspector Taylor:** Yes, I've seen it. I haven't read it thoroughly, but he would make an inspection similar to ours.

**Mr. McClellan:** Just to clarify, this is the May 1978 Manson report that you're referring to—

**Mr. Leluk:** I believe that's the one, yes.

**Mr. McClellan:** —that the ministry tabled with us?

**Mr. Leluk:** Yes, that's the one. Are either or both of you gentlemen familiar with the Queen Street Mental Health Centre?

**Inspector Taylor:** Not I.

**Mr. Bateman:** No, I can't say that I am either. I know we did approve the plans for the new building though.

**Mr. Leluk:** So then you wouldn't have any idea how these fire safety features at Lakeshore would compare with those at the Queen Street facility for inpatients?

**Mr. Bateman:** Not really. Again, this is very difficult to assess. If you were asking the question, "Does the Queen Street Mental Health Centre comply with the Ontario Building Code," the answer there is yes. So that's some measure, I suppose, of the relative status, but it's a far bigger building. The bigger the building, the greater potential for a serious fire. So I can't really rate them in answer to your question.

**Mr. Leluk:** Are either or both of you gentlemen familiar with the McKinsey report and have you seen it?

**Mr. Bateman:** No, I've just seen comments on it and I never thought I would be as familiar as I have been in the two sessions I spent waiting here.

**Mr. Leluk:** What I want to refer to particularly in the report is, it was stated that at Lakeshore, for example, a recent survey by the Ministry of Government Services and several communications with Ontario Hydro have established that electrical wiring is old and overloaded, the building being, I

believe, some 89 or 90 years old, and at both Lakeshore and Whitby psychiatric hospitals fires are an ever-present danger because of this faulty wiring. At Lakeshore the top floor has had to be abandoned in several buildings. I've toured that facility and I found this to be the case. Would you agree with these quotations regarding the faulty wiring?

**Inspector Taylor:** I really can't say. I'm a Hydro inspector, but I understand the third floor was abandoned because it was a dead-end situation.

**Mr. Kennedy:** What you you mean by that?

**Inspector Taylor:** On the third floor of certain parts of the buildings on E, D and C, there was only one way off the third floor and it was not being used, I think, since 1969.

**Mr. Kennedy:** So it was an access situation on egress rather than—

**Mr. Leluk:** That's my understanding.

**Mr. Kennedy:** —rather than a potential fire hazard.

**Inspector Taylor:** Electrical, I'd leave up to the Hydro.

**Mr. McClellan:** Just to pursue Mr Leluk's line of questioning, did either of you gentlemen ever receive a copy of this Ministry of Government Services report that is referred to in the McKinsey report?

**Inspector Taylor:** I haven't.

**Mr. Bateman:** No.

**Mr. McClellan:** Have you received reports, either of you, from Ontario Hydro with respect to defective wiring at Lakeshore?

**Inspector Taylor:** Not as far as we know; not the Etobicoke Fire Department anyway.

**Mr. McClellan:** Would it be the normal practice of Ontario Hydro to advise either of you gentlemen if they had determined that there was a fire hazard as a result of defective wiring?

**Inspector Taylor:** I can't recall their sending us anything like that.

**Mr. Bateman:** They would normally take corrective action themselves and I think there's been enough electrical work carried out over the past decade at Lakeshore hospital that their inspectors would have been in there. I can't comment on whether this is a low capacity problem that doesn't allow the hospital the flexibility to add air-conditioners and so forth.

**Mr. Leluk:** From the statements in the consultants' report I believe it's a problem with overloading and with the electrical



wiring being old. I would think one would expect that with an 89-year-old building you would have these problems with wiring. I think common sense would tell you that.

**Mr. McClellan:** What I'm trying to determine through questioning and have yet to be able to determine, Mr. Chairman, is where is the evidence that there is defective electrical wiring that constitutes a fire hazard?

**Mr. Bateman:** I don't think I can enlighten you on that point. Normally Mr. Manson or the fire department would see obvious symptoms of defective wiring and they would at that point call in Ontario Hydro, who would order corrections.

**Mr. McClellan:** But you have seen no obvious symptoms of defective wiring in the course of your work?

**Mr. Bateman:** It seems that any time we've responded to the Lakeshore it hasn't been from defective wiring.

**Mr. McClellan:** Right. Have you had any concerns expressed to you from any sources with respect to fluorescent fixtures within Lakeshore Psychiatric lacking thermally protected ballasts?

**Mr. Bateman:** No. Nobody has indicated that to us.

**Mr. McClellan:** Right. So that's not something that's ever come across your desk or that you've been asked to respond to?

**Mr. Bateman:** No.

**Mr. McClellan:** Again, just so that I understand. I'm not thoroughly familiar with the various divisions of responsibility around yourselves, the Ministry of Government Services, Ontario Hydro, and Lakeshore's own fire safety staff. Would either of you undertake in the course of your normal work to look at the fluorescent fixtures to determine whether they had thermally protected ballasts?

**Mr. Bateman:** No, not I. I've probably asked general questions of a number of people about whether they had problems in certain areas and if they indicated yes then we might institute inspection by Hydro, but nobody has indicated he has had problems.

**Mr. McClellan:** Right. This is in parenthesis. My dilemma remains, Mr. Chairman, to understand where the evidence of fire hazard from defective wiring or electrical installations comes from. There was a fire incident on November 19, 1978. This was the incident that caused the Minister of Health (Mr. Timbrell) to be woken from a sound sleep. Do you know what was the cause of the fire? Specifically, was the fire caused by some deficiency in the building?

**Mr. Bateman:** No, it was arson. There was a fire on November 18, and then a subsequent fire on November 19, and they were both arson.

**Mr. McClellan:** They were both arson. Is there anything anybody can do about that?

**Mr. Bateman:** It is very difficult. Perhaps supervision might help alleviate the problem.

**Mr. McClellan:** Just finally, your overall conclusion, as two people who are responsible for fire safety, is that the building does not constitute a fire hazard? Is that a fair—

**Mr. Bateman:** Bearing in mind that every building is a fire hazard in itself, I would say this is fairly well up on the spectrum as a safe building.

**Mr. R. F. Johnston:** Mr. McClellan asked most of the questions I was going to ask, but there are a couple. One of them has to do with the number of times you, as the Etobicoke Fire Department—and not necessarily yourself, but someone from there—would go to Lakeshore during the course of a year to check out things. What sort of rapport do you have with the fire prevention officer there?

**Inspector Taylor:** It has been our policy to inspect it every year. I think we missed one year—it might have been 1974, I am not sure—but we have left the understanding that if any problem or something they were not sure of arose they should give us a call and we would certainly try to give them a hand. If we were stuck for the answers, then we would hit it off down to John's office and see if we could come up with them, but the rapport was good.

**Mr. R. F. Johnston:** Okay. In the two cases of arson that we were talking about, was there anything about the nature of the fire itself after it was set—the reporting of it, the speed in putting it out, anything like that—that concerned you, that gave you cause for concern, in terms of the reporting mechanism?

**Inspector Taylor:** Not me myself. The report here is that they usually respond to where the annunciator panel is, but apparently after five o'clock there is no longer anybody responsible for that area, so the first truck in naturally went to the area where the annunciator panel was. There was nobody there. But the second truck in came in from the other way and they spotted the fire, so it was only maybe a matter of 30 seconds to a minute between the two.

**Mr. R. F. Johnston:** Okay. So it is not a major problem.



The other question I have is, has the Minister of Health ever approached either of your departments to ask you to go in regarding safety factors in the hospital at all?

**Inspector Taylor:** Not that I can recall.

**Mr. Bateman:** No, he hasn't. We work very closely with the fire safety officers in the Ministry of Health, Mr. Manson and Mr. Quinn, so there really isn't the necessity. There is very close liaison between our office and their office.

**Inspector Taylor:** I might add that any time we have written a report on the hospital, a copy did go to Mike Manson and also a copy to the Ontario fire marshal's office, so they were aware of anything we have said since 1969.

**Mr. Jones:** I have one brief comment, I suppose, for Mr. Bateman. Incidentally, it comes as a surprise to me, just as an observer, that you people seem to be giving the opinion that it is safe. I am happy to hear it, incidentally. It happens that I come by way of an insurance background and I was an underwriter and had some training in some of those areas, so that is just an impression. If I were going to see it, I don't know whether my company would be insuring it.

But anyway, Mr. Bateman, where does the fire marshal's office come into play? Is it only in the event of a fire or, as you say, do you interface with the fire safety officers of the ministry? Are they two separate functions?

**Mr. Bateman:** First of all, it is a safe building in the context of a building of that vintage. One can go on qualifying that statement. Our office investigates fires of an incendiary nature, arson fires and large loss fires and where there has been a loss of life.

The other manner in which we get involved with institutions and government buildings is through our plan approval program where there are new projects being constructed or renovations. The third way is working with the local fire departments where they do want our assistance in their fire prevention duties.

[5:15]

**Mr. Jones:** Mr. Taylor, perhaps you could tell us, have you had occasion to call on the fire marshal's office relative to Lakeshore?

**Inspector Taylor:** No, it's perhaps a case of interpretation. When they put in the new trades building, for instance, something

might pop up relating to a fire wall and I might phone down to the plan examiner, for instance, and say, "Is this where the fire wall is supposed to go?" We check things like that. I could be looking at it but not really sure if this is the fire wall I am looking at. So I would go down to the plan examiner, look at the plans he would show me and go back to the hospital and say, "Yes, this is where the fire wall is to go."

**Mr. Jones:** May I just ask, and I guess I should know, but what is the structure of that building? We just had occasion around here where someone asked if this would pass the current code, and one of the pictures in there was the framing that happens to be in the ceiling of this old building. Is this a frame ceiling in this building or what would be called a brick joist basic construction?

**Inspector Taylor:** The ceiling in that building is wood.

**Mr. Jones:** Whereas something like Queen Street would be referred to as, what, concrete?

**Inspector Taylor:** The third floor was never occupied so really you had a two-hour separation between the floor that wasn't occupied and the floor below. When you are talking about a combustible roof, it was really separated by a floor and had a two-hour fire separation between it and the floor below.

**Mr. Jones:** The floors are concrete, aren't they?

**Inspector Taylor:** Yes.

**Mr. Chairman:** Well, thank you very much, Mr. Bateman and Mr. Taylor. We appreciate your appearance and you've been a big help. We have gone by adjournment hour and as is usually the case we still have in this instance a group of witnesses from whom we would like to hear. I wonder if the union would agree to come back perhaps on Tuesday. We have a full schedule Monday. Would that be convenient?

**Mr. O'Flynn:** Sure, that would suit us fine.

**Mr. McClellan:** Could we make an agreement that regardless of where we get on Monday, we start the Tuesday session with the union delegation? They have been here a number of times, and especially with respect to the size of the delegation—

**Mr. Chairman:** Yes, I think we can agree to do that at the same time that we agree to try to complete Monday's agenda. I don't think it's an impossible agenda and I would hope to get—

**Mr. McClellan:** Can you run over it again for us, Murray, whom we will be hearing from Monday?

**Mr. Chairman:** Yes, we will be hearing from Mr. Howard Richardson; Mrs. Audrey McLaughlin who is the executive director of the Metro Mental Health Association; Dr. Olsen, director of outpatients, Lakeshore Psychiatric Hospital; Alderman Janet Howard; and Mr. Beare Weatherup. He's from Parkdale, associated with the tenants' association.

**Mr. Conway:** Do you anticipate getting that list completed on Monday?

**Mr. Chairman:** If I have agreement from the committee to enforce time limits, I think we could.

**Mr. McClellan:** I will be quite happy to ask the chairman to rule with an iron hand on Monday and even to go so far as to set some constraints.

**Mr. Chairman:** I would be glad to do that if I could have an agreement from the committee. I'm not really a martinet.

The committee adjourned at 5:19 p.m.

## SPEAKERS IN THIS ISSUE

---

Conway, S. (Renfrew North L)  
Dukszta, J. (Parkdale NDP)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Jones, T. (Mississauga North PC)  
Kennedy, R. D. (Mississauga South PC)  
Lawlor, P. D. (Lakeshore NDP)  
Leluk, N. G. (York West PC)  
McClellan, R. (Bellwoods NDP)  
Ramsay, R. H. (Sault Ste. Marie PC)  
Rowe, R. D. (Northumberland PC)

**From Queen Street Mental Health Centre:**

Anderson, Dr. D., Director  
Durost, Dr. H. B., Medical Director

**From Toronto General Hospital:**

Munroe, Dr. A., Chief of Psychiatry

**From Etobicoke General Hospital:**

Rzadki, Dr. E., Chief of Psychiatry, Member, Mayor's Task Force on Mental Health

**From Etobicoke Public Health Department:**

Butchart, Mrs. O., Member, Mayor's Task Force on Mental Health

**From the Office of the Ontario Fire Marshal:**

Bateman, J. R., Ontario Fire Marshal

**From Etobicoke Fire Department:**

Taylor, Inspector R.

**From Ontario Public Service Employees Union:**

O'Flynn, S., President





Ontario

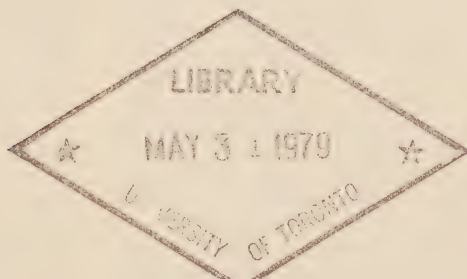
No. S-11

# Legislature of Ontario Debates

## Official Report (Hansard)

**Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Monday, May 7, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

## LEGISLATURE OF ONTARIO

---

MONDAY, MAY 7, 1979

The committee met at 3:25 p.m.

### MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Chairman:** I will call the meeting to order. You may recall at our last meeting the chair was given the authority to outline a time schedule and to abide by it rather firmly, so I intend to do that today. We have set out half an hour for each of our witnesses today and with the committee's support I will, at that time, cut off any further discussion. Although I hope we can complete the questioning of all of our witnesses within that time frame, if not, I'm going to have to move on in accordance with the time schedule arrived at.

**Mr. Lawlor:** Let me interject. Mr. Kennedy isn't here. He was going to have a report from the steering committee which met this morning. On time, it's not as critical, perhaps, as it once was. The minister has asked not to come till next Monday, and with the minister will be Mr. Jappy, and there will be one further witness at that time and that should wind up that hearing. The minister has asked us particularly; we acceded to it on certain conditions.

If you want to know what those conditions are, I will tell you; namely, that we not do anything with respect to the Lakeshore property, with respect to staff, with respect to patients, until such time as a report of this committee is submitted to the Legislature and is debated, and we get an answer from the Legislature itself. That was my alternative condition. I haven't heard back yet. I don't expect to. It was only a couple of hours ago that this was submitted. In any event, he will not be showing up. Therefore, on Wednesday we have very few witnesses.

**Mr. Chairman:** I think we can always fill that in a little, Mr. Lawlor. I can see that perhaps on Wednesday our time would be a little freer, but we did slate our witnesses in today for specific times and I think we should abide by that.

**Mr. Lawlor:** I bow before a chairman, because I happen to be one.

[3:30]

**Mr. Chairman:** The other matter has to do with our visit on Thursday; I believe there was some request that Mr. McMullen conduct the tour at Lakeshore and, perhaps, Mr. Fisher accompany us at the Queen Street tour. I would hate to suggest that unless we had those people come along, we couldn't tour the places, but, if those people could come along in accordance with the schedule the ministry is setting up, it would be helpful. Also, I think the chief union steward, Mr. Sam Wood, was suggested as a possible member of the entourage and if Mr. Wood could accompany the group, that would be helpful as well. I make that suggestion in accordance with the request and if it could be accommodated, it would be helpful.

Our first witness today is Audrey McLaughlin, who is the executive director of the Metro Mental Health Association. Do you have an opening statement, Ms. McLaughlin?

**Ms. McLaughlin:** I would only say that the Mental Health Association has been very concerned about the closure of Lakeshore, particularly about the planning process around that closure. I should perhaps read to you the position that we sent to the minister which is basically that we would not oppose the closing of Lakeshore Psychiatric Hospital provided a suitable range of alternatives is in place, meaning community services, particularly. In a further letter in January, sent by our president to the minister, we outlined again the need for the planning process and for alternatives to be in place before the actual closure took place.

**Mrs. Campbell:** Are you suggesting by any chance that we don't have ample services in place already prior to the closing of Lakeshore?

**Ms. McLaughlin:** I'm sure I'm not the first one to suggest to you that there are not ample community services throughout Metropolitan Toronto. Certainly, the closure of Lakeshore will exacerbate the existing



problem. Our association has been particularly concerned with residential alternatives. We have been making presentations to the municipalities about this issue, and are interested in what the province is doing. Two years ago we did a study of psychiatric services in Metropolitan Toronto and one hears the same problems over and over again; nothing changes and nothing has changed in two years. I am very concerned that the Ontario Council of Health will have heard exactly the same things. What's going to happen when that report comes out in June, I don't know, but there's been no significant change in mental health care in Metropolitan Toronto in those two intervening years at least.

**Mrs. Campbell:** In view of the concerns about alternative care in the community, could you give us some idea as to any resolutions you may have had as to providing a standard for such care and who should be responsible for that kind of planning?

**Ms. McLaughlin:** First of all, I probably don't need to give you my speech about how mental health care has been ignored and I suppose, if the government can be applauded for anything, it is the announcement of the closing of Lakeshore because that announcement has made people finally deal with some of the issues. Nothing else has. I would say in terms of program standards, if you are talking about residential alternatives, there are proposed parallels in children's services. I think that certainly there do have to be program standards. Right now, in terms of community services, particularly residential ones, what has happened is that we have an unplanned, unco-ordinated, unregulated system which operates only with the co-operation of our existing mental health system and that is the commercial boarding home which, in Metropolitan Toronto, probably serves about 800 people. It's not to say they're all bad, but that's an example of an unplanned system, no money going into services, and it is not meant to be a therapeutic alternative to hospitalization.

**Mrs. Campbell:** Could you answer the question as to who you think should be setting standards and enforcing them?

**Ms. McLaughlin:** Obviously the province has to take some responsibility in setting standards. Having dealt with the municipalities to some extent both outside of Toronto and in Toronto, I think the general agreement is that the province should set general standards, but the enforceability of those, hopefully, could be incorporated into the municipal structure in some way. I think

there are models in other cases where this has been done that would be quite appropriate.

**Mr. McClellan:** Ms. McLaughlin, you sit on Dr. Lynes' committee, I forget the name.

**Ms. McLaughlin:** Outpatient steering committee, I think it's called.

**Mr. McClellan:** I understand the committee is in the process of receiving and vetting and forwarding proposals for community-based mental health care services. How many proposals have been received, approved, and passed on to the ministry with a recommendation for support at this point?

**Ms. McLaughlin:** Proposals have been reviewed, as you may know. The process of the committee was that community consultation meetings be structured in each of the boroughs, cities and municipalities, affected in the Lakeshore closure area. So each of those—in other words, Peel, city of Toronto, York, North York and Etobicoke—has presented plans with regard to outpatient services. Those have been reviewed by the committee. I believe we're meeting in another week or two to look at the financial implications. Of course, there were financial figures attached to the proposals, but that has to be sort of run through. Does that answer your question?

**Mr. McClellan:** You'll continue to review submissions that you have, try to cost them out, and then submit them to the ministry for approval.

**Ms. McLaughlin:** The conclusion, I think, is that there are two kinds of submissions. The ministry, I understand, has committed that there would be no reduction of funds to outpatient services. One of the problems, as I see it, is that there are also adult community mental health moneys, which is another parcel of money.

Apparently, \$1.3 million of the savings is supposed to go towards that adult community mental health money. One of the problems I see and one of the questions I've raised at the committee is how to assure and track the outpatient moneys; for example, to the region of Peel. This proposal, which I think makes a lot of sense, would hopefully provide service to the number of outpatients currently using Lakeshore from the region of Peel. It's a very good proposal, and I think fairly comprehensive, in that it has residential services, it has increased general hospital services, and so on.

However, how does one fund that? The budgets will not be attached to Queen Street in any way, in other words the ministry's flow of outpatient funds would be through

Queen Street. So, a way has to be found that the outpatient money doesn't get lost, and that it's seen that all the adult community mental health money—because there are two parcels of money—

**Mr. McClellan:** The \$1.6 million and the \$1.3 million?

**Ms. McLaughlin:** Yes.

**Mr. McClellan:** And the \$1.6 million is for the—

**Ms. McLaughlin:** Outpatient service.

**Mr. McClellan:** —retention of outpatient services that are currently being operated at Lakeshore, and the \$1.3 million is for—

**Ms. McLaughlin:** Is "additional."

**Mr. Kennedy:** You mentioned the region of Peel. Do you mean the health units, the social and family planning association?

**Ms. McLaughlin:** There are two hospitals in Peel. There's a district health-care—

**Mr. Kennedy:** No, no. You mentioned, for example, the region of Peel has said such-and-such—

**Ms. McLaughlin:** Oh, I'm sorry, I don't mean the formal municipal region of Peel.

**Mr. Kennedy:** No, but within it we have the Peel regional health unit, we have the social planning council and we have the family association. Which one do you mean?

**Ms. McLaughlin:** All I meant was the area of Peel. In other words, there's a district health council for the area of Peel; it has a mental health services committee, and on that committee there are representatives of the groups you have mentioned.

**Mrs. Campbell:** They had four proposals, as I understand.

**Ms. McLaughlin:** I think it's five now.

**Mrs. Campbell:** Five? And one was approved. By whom? I thought it was by you.

**Ms. McLaughlin:** I'm not sure. The total package was approved in principle by the Lynes committee.

**Mrs. Campbell:** I see.

**Mr. McClellan:** I just want to try to get this straight in my head. Is it \$1.6 million that's available for Lakeshore or \$1.9 million?

**Ms. McLaughlin:** My understanding is that it's \$1.6 million— but there are so many figures going around.

**Mr. McClellan:** The figure of \$1.9 million hasn't been bruited about at all in your committee?

**Ms. McLaughlin:** No, \$1.3 million is the community mental health money, as I understand, and \$1.6 million—those are the figures I've heard.

**Mr. McClellan:** And you're dealing with the \$1.3 million?

**Ms. McLaughlin:** Yes.

**Mr. McClellan:** Of the proposals that you've received in your committee, how many of them are actually new proposals and how many of them are proposals that have been submitted to the Ministry of Health in previous years and turned down?

**Ms. McLaughlin:** My guess is—and this is a guess, because I don't have a count—no, that's not right, because proposals were solicited last year for the community mental health moneys. They were solicited without anyone knowing that Lakeshore might close. One has to be clear that those kinds of proposals are very important ones to augment community mental health services. They were not designed to replace an outpatient service. I think that's important to keep clear. So there are many of those that are "old" proposals. The Etobicoke proposal—which is basically a revamping of the system, if you like, in Etobicoke, in establishing community mental health centres—is totally new, but parts of that would incorporate some of the old proposals.

**Mr. McClellan:** This is the mayor's task force you're talking about?

**Ms. McLaughlin:** No. This is another one, which arose out of the community consultation meeting.

**Mr. McClellan:** Are you saying that a number of the—I'm still not sure that I understand—

**Ms. McLaughlin:** How many? Exactly? Probably half and half. I think that would be a fair estimate.

**Mr. McClellan:** And half of the proposals in front of you are proposals that have been through some kind of a grant application process prior to the current committee meeting, and presumably have been turned down for lack of funds.

**Ms. McLaughlin:** Yes, for lack of funds, I would assume. Last year, as you may know, there were 35 proposals throughout Metropolitan Toronto for community mental health programs. Two of those were funded.

**Mrs. Campbell:** Everything is in place for the closing of Lakeshore.

**Ms. McLaughlin:** I'm not sure they would replace the outpatient programs. That's the tricky thing.

**Mr. McClellan:** I understand they were designed as enrichments to an existing outpatient program.

**Ms. McLaughlin:** That's right. I'm not



denying their importance, by the way; I think they were very important.

**Mr. McClellan:** This will be my last question. Has your committee work involved you in looking at the question of the security of the existing outpatient programs at Lakeshore? Has that been one of the terms of reference of the Lynes committee?

**Ms. McLaughlin:** I'm not sure what you mean by "security."

**Mr. McClellan:** Are they going to survive or not? By way of example, I think particularly of the behaviour therapy clinic, wherein four of the six staff have been laid off, and the director has expressed publicly his doubt that it's possible to continue the behaviour therapy which, as you know, is run largely on a volunteer basis.

[3:45]

**Ms. McLaughlin:** You see, this is the bind one is in, and all of you wise people would know this much better than I. We are assured that the outpatient services will remain and the moneys to those outpatient services will remain. They may not be the same individuals because of seniority and union negotiations and so on. Until the cards are all on the table and they are in place, how does one know? This has been the assurance that has been repeatedly asked for and repeatedly given. You may have the inside dope, but I don't.

**Mr. McClellan:** We haven't had any better luck than you have, after two weeks of hearings.

**Ms. McLaughlin:** The thing is, you either say everybody is a liar or you wait and see if these things are going to get funded and get in place. I think the essential question is, if there is any commitment to community mental health why only 1.3 million, why not all the money into developing a range of alternatives? I think that is perhaps a valid question.

**Mr. R. F. Johnston:** Why not plan it first?

**Ms. McLaughlin:** That is certainly a unique thought.

**Mr. McClellan:** Just a final question: When will your committee have a package of proposals ready, approved and presented to the ministry? Have you got a timetable?

**Ms. McLaughlin:** I don't have when the next meeting is. I know that we met last week, that all of the ones I mentioned to you were approved in principle and were to be reviewed by the financial people and we were to be called back.

**Mr. McClellan:** Is that ministry financial people?

**Ms. McLaughlin:** Ministry financial people, yes, sir.

**Mr. McClellan:** Do they exercise a veto over the submissions at this stage?

**Ms. McLaughlin:** I would think not; I would think it would be the committee which would.

**Mr. McClellan:** You are circumscribed then only by the \$1.3 million ceiling on the amount to be expended?

**Ms. McLaughlin:** That is my understanding.

**Mr. McClellan:** It will be interesting to see.

**Ms. McLaughlin:** I think this is the real difficulty. You have to see the commitment of money.

**Mr. Leluk:** Ms. McLaughlin, I see that you are the executive director of Metro Mental Health Association. Could you, for my benefit, and maybe some of the other members of the committee, tell us what Mental Health Metro is and what it does?

**Ms. McLaughlin:** We are a branch of the Canadian Mental Health Association, which is a national association. We are a voluntary association, primarily supported by the United Way. The goals are to promote mental health and to be involved in the caring and treatment of the mentally ill. It is a citizens' association. We have a membership of approximately 2,000.

**Mr. Leluk:** Does your association have any particular view on the psychiatric treatment in provincial psychiatric institutions as opposed to the community setting, programs out in the community? Do you have any particular view on that?

**Ms. McLaughlin:** We do, yes. I think it would be foolish to say that there should never be psychiatric hospitals; at this point the state of the art of psychiatric treatment probably doesn't warrant that kind of view. Our views, as expressed in this psychiatric task force report, are that you must have a comprehensive range of services. Whether treatment is better in an Ontario psychiatric hospital than it is in a general hospital, whether it is from a private psychiatrist, or whether you don't get any at all, is a very difficult problem.

I would suggest to the committee that I am empathetic to your problem, because you can talk about bricks and mortar and numbers, but recently we just did a housing position paper with another organization, the community resource consultants, where we were trying to make the case to the government for designing a comprehensive



range of residential alternatives. One response I received was from a very eminent psychiatrist in Toronto who said the best place for psychiatric treatment for psychiatric patients, in his and his colleagues' view, was a psychiatric hospital.

I received another letter from a very eminent international psychiatrist who works out of Toronto who said that people are in hospital far too long and that they should be treated in the community. So you are dealing with a very difficult problem that, as to the quality of treatment, I think is very difficult to comment on.

**Mr. Leluk:** Does your association see any advantages, say, to the treatment of patients in community-based settings? Do you see advantages to this, and what would some of these advantages be?

**Ms. McLaughlin:** I think based on some of the models—BC has some very good models and there have been some models in the States—that the key again is to have a range of alternatives so that treatment in hospital is as short as possible and when the person leaves there is a therapeutic setting for the person to go to and there are vocational supports. I mean, treatment isn't just going in and being talked to and given therapy. It's also your social and vocational relationships. Treatment in hospitals should be as short-term as possible; I'm not sure it's either/or. I think there is time for—

**Mr. Leluk:** But there are some advantages. You agree there are some advantages?

**Ms. McLaughlin:** Our research would indicate there is.

**Mr. Leluk:** And the outpatient programs?

**Ms. McLaughlin:** Sure, and I think in talking to lots of patients and their families that there is.

**Mr. Leluk:** Right. How long have you been sitting on this committee that's been looking at outpatient facilities?

**Ms. McLaughlin:** I believe it began in January.

**Mr. Leluk:** What would you say of the quality of the submissions that have been made to your committee? Could you tell us something about these submissions and your impressions of them?

**Ms. McLaughlin:** My impressions are that whenever anything is up for grabs, such as with the closing of the hospital which means \$1.3 million, there's a lot of lobbying for the money. What I think has been very positive, as I mentioned before, is that the announcement of this closure has made people think about mental health services. I

don't know whose idea it was to build Queen Street to 700 beds. It's ridiculous, and I don't know who's thinking now about the rebuilding of Whitby, but I certainly hope this committee is going to think about it because you're going to have another big problem to deal with when you get around to that one.

However, I would say on the quality of submissions, what has happened I think is that the community consultation process, which is always horrendous because you get professionals vying with each other for their piece of the pie, has come together. On the whole I would say the proposals have been really excellent—Etobicoke's particularly, and Peel's. They're the most affected areas and their proposals I think have been quite comprehensive.

**Mr. Leluk:** How significant do you feel the \$1.3 million commitment by the Minister of Health (Mr. Timbrell) will be in easing the pressures on the Queen Street Health Centre? This is the commitment to broadening the community-based programs in the Lakeshore area?

**Ms. McLaughlin:** I think it depends on how well it's done. Right now a lot of money is spent in mental health. It's unco-ordinated and a lot of bucks are being spent, but nobody is co-ordinating those. I think if there's no co-ordination built into the system, they can spend \$10 million and it will fall flat on its face. A good planning system would help. Remember that it's not just the \$1.3 million that's supposed to take the burden from Queen Street, it's the \$1.6 million plus the \$1.3 million, whatever that is.

**Mr. Leluk:** But you're saying if the programs are well co-ordinated the money should have some substantial effect?

**Ms. McLaughlin:** And if the funding bases are relatively stable. If it's going to get into a system, I think there has to be an assurance. We have been assured of this and I presume you have been assured that the \$1.3 million, for example, is not a one-shot deal, because there's not much point to that.

**Mr. Leluk:** I would think there should be some ongoing funds for continuing these programs. This is one of the questions I posed to the minister myself, being a member from that area.

I have just one other question, Mr. Chairman. Given the surplus of inpatient beds, not only at the Queen Street Mental Health Centre but also at the Hamilton Psychiatric Hospital, and the fact that

they're going to broaden these outpatient programs in the Lakeshore area, do you feel under these circumstances that the Lakeshore Psychiatric Hospital should be closed?

**Ms. McLaughlin:** Our feeling is, as I read the statement in the beginning, that if these services are in place it is an opportunity for us to look at the setting up of a community mental health model. I don't think enough study has been done or indeed whether it is Peel that should have an additional hospital. The McKinsey role study, which I'm sure you've heard lots about, set out with particular terms of reference that were very limited, and I don't know whether Peel is the area with the largest growth. Our view is that if the moneys were well spent, well planned, well co-ordinated, and there are enough beds in Queen Street—we just have to rely on the figures that we get from others, we don't have the inside information on that—that is a system we should look at very seriously. We might end up with a better system if it's well done. If it's poorly done, we'll just reap all the problems that that's going to bring.

**Mr. Leluk:** That's all I have, Mr. Chairman. Thank you.

**Mr. Chairman:** Mr. Johnston, Mr. Sweeney and Mr. Lawlor, and we have six minutes left.

**Mr. R. F. Johnston:** I'm not clear. Am I getting a picture of a fairly chaotic approach to try to make decisions at this moment on that committee? Is it?

**Ms. McLaughlin:** No, I don't think so. I think what was chaotic was when at the community level you would bring people together and say, "You have to come up with the proposal for your whole area in 48 hours." That's what I meant was chaotic. What I did say I think is positive, is a lot of good stuff has come out of that, particularly from the community group. The hospitals are a little slower, but they're getting there.

**Mr. R. F. Johnston:** You're also presenting a picture of various groups coming in on their own to the committee and the committee having to make some decision about how these will all fit in a fabric for that community and whether there would be more or less organization. You talk about Etobicoke turning itself upside down. That sounds like a pretty comprehensive kind of planning process. I just wonder how you, as a committee, have decided to identify those additional needs that will be required because of the hospital closing. What are you using as your parameters to decide?

**Ms. McLaughlin:** Well, the needs were identified in the communities—in Etobicoke, in North York—by those communities and services in those communities.

**Mr. R. F. Johnston:** That's the presumption from existing services of what would occur if Lakeshore were to close and how that would affect them.

**Ms. McLaughlin:** As well as how existing outpatient services might be integrated with what exists, whether it's a multi-service centre or whatever, and whether additional services were necessary.

**Mr. R. F. Johnston:** Have you looked at outside or external models in terms of the closings such as those from the United States?

**Ms. McLaughlin:** All of us are familiar with some of the models that have been used. Certainly, we are familiar with Massachusetts and some of the bad ones and some of the good ones. Pretty well everybody on that committee has had some experience in looking at that. Nobody professes to be an expert, I don't think, because I don't think anybody knows because it's so new.

**Mr. R. F. Johnston:** They're all my concerns. I guess I made that kind of sarcastic comment about planning being done in advance because it would have been nice to plan then instead of now—under the gun, as it were.

**Ms. McLaughlin:** I agree. I don't think anybody in our association would disagree with that. Our association certainly would not disagree with that. It's not a good planning process at all.

**Mr. R. F. Johnston:** I'm worried about the commitment to that kind of planning in an integrated focus, not just because you said nothing has happened in the last two years. We've known for ages that we need an extensive and a very subtle network in the Whitby example. In my view, what is going on in the rebuilding shows us they're dealing with a political dynamite in Lakeshore at the moment and therefore, responding and trying to do some supposed planning. Yet there's no focus, because everybody's focusing on Lakeshore and nothing's happening. Can you tell us a bit about the lack of communication that's going on at Whitby? I'd just like that to be juxtaposed.

**Ms. McLaughlin:** Well, again I can only give you my observations. I was at a meeting last week where the closure was discussed and there were representatives from the ministry present. I'm very concerned because I don't know on what therapeutic models the



planning is being done. I don't know whether in fact the planning is being done on the basis that there should be one hospital in Whitby or a little one in Lindsay, with a smaller one in the other catchment areas. I think this is very concerning. Quite frankly, I think it's great you're all here together but, you know, it's a crisis. All of us, including our own association, should have yelled louder when Queen Street was built. If Queen Street hadn't been built to 700 beds, I dare say we wouldn't be sitting here. If Whitby goes the same route we'll just be having this round of crisis meetings again.

As far as communication is concerned, I found it very difficult to find out. I understand the architects are working. I'm not sure what that means.

**Mr. R. F. Johnston:** My understanding is it is for one hospital in Whitby at approximately—

**Ms. McLaughlin:** That's my understanding.

**Mr. R. F. Johnston:** —the bed size that exists at present, and so it would not be decentralized in smaller units.

**Ms. McLaughlin:** Well, my question is, who accepts that? Do you just wait until it rises from the ashes and say, "Oh, it's one hospital." Our association is very interested in being involved in looking at that because I think there's also a concern that more community outreach services from Whitby are very necessary, as McKinsey pointed out.

**Mr. R. F. Johnston:** Exactly. I've worked in that area and have recognized that. I would just put to you my view, unless there is a public outcry there, which isn't likely when you're holding on to jobs, you're not going to get that planning. The reason you're getting this other supposed planning is because of the crisis.

**Ms. McLaughlin:** There were 200 people at a meeting last week who were fairly vocal.

**Mr. R. F. Johnston:** Upset? Good, wonderful.

**Ms. McLaughlin:** Not upset, no, but they were fairly vocal. You see, nothing has happened to be upset about yet.

**Mr. Chairman:** We have one minute, Mr. Sweeney.

**Mr. Sweeney:** Okay, one question. Ms. McLaughlin, you have a Metro overview. An earlier witness described a different process operating in the Scarborough area. Are you familiar with it?

[4:00]

**Ms. McLaughlin:** There are a lot of things operating in the Scarborough area.

**Mr. Sweeney:** Well, they seem to suggest a great deal less reliance on psychiatric hospitals. Is that your experience? In your judgement, does it work well? Could it work someplace else, or is there something unique about that area?

**Ms. McLaughlin:** I am sorry, but what did you mean about Scarborough? Is it because Scarborough is so far from Whitby? Is that what you mean?

**Mr. Sweeney:** No, our understanding from a previous witness was the arrangement of services for psychiatric patients, mentally ill patients, in the Scarborough area was less reliant on the psychiatric hospital, including Whitby.

**Ms. McLaughlin:** Yes, I understand that.

**Mr. Sweeney:** Was this because they made more use of other community-based services?

**Ms. McLaughlin:** I don't think there are a lot in Scarborough, but I would agree. I think that's a sort of interesting question to think about because the farther away the hospital from the Ontario Hospital, perhaps the more that is done in the community. You can carry that too far, but is that what you are saying? It is my understanding that there is less reliance.

**Mr. Sweeney:** I am wondering whether, with your Metro-wide background, that is the kind of experience you had or whether the previous witness looked at it from a different point of view.

**Ms. McLaughlin:** That's my understanding with Scarborough. We have a group in Scarborough and it is my understanding the hospital is used less.

**Mr. Sweeney:** Do you have any reason to believe the needs are not met there? Have you had any outcries?

**Ms. McLaughlin:** No, not particularly, no.

**Mr. Chairman:** Mr. Sweeney, I am afraid we are out of time.

**Mr. Sweeney:** Okay.

**Mr. Chairman:** I realize that Mr. Lawlor and Mr. Kennedy also have questions. I apologize, but we are just out of time. Thanks very much, Ms. McLaughlin.

Mr. Miller, the Treasurer, is with us. Mr. Miller, I believe the committee has a few questions. I am sure you feel right at home here with your colleagues.

**Hon. F. S. Miller:** I do.

**Mr. Laughren:** With some more than others.

**Hon. F. S. Miller:** My allies are on my left.

**Mr. Chairman:** Do you have a statement?



**Hon. F. S. Miller:** No, I don't have a statement, although I could try to briefly summarize orally my contacts with this problem and what's happened in the years I've been around. Since I am not sure what the committee really wants, I think I'd rather have you ask me questions than have me go on at great length about something you don't want to know.

I guess my first contact with the financing of health-care costs occurred when I was made Dr. Potter's assistant in the fall of 1972. My first recollection of any personal involvement was during a federal-provincial first ministers and Treasury ministers' conference in Ottawa in January 1973. I attended as an observer.

At that time, the federal government was reasonably satisfied, as I recall, with the health-care financing. As you recall, they had had two programs, the medical program and the hospital program. They theoretically financed 50 per cent of these. I say theoretically because it was weighted for each province according to the number of factors. Ontario, I think, got around a 42-44 per cent share, in fact, after allowing for the weighting.

The province of Ontario at that time, and I suspect Quebec, certainly later Quebec, were anxious to convert the program from being shared cost to some kind of formula. At that point, the Treasurer of the day was asking for tax points, as I recall. Certainly, over the next couple of years we discussed tax points. This was during my first year or so as Minister of Health. Remember in those days, health-care costs had gone up 25 per cent in one single year.

We were making reasonably good progress towards a new formula when around June 1975, just before the 1975 election, rather abruptly the federal government announced it was putting limits on the growth of health care on the medical side starting in the next fiscal year. I think the limit was 14 per cent that year, dropping down progressively for about four years.

The Ministers of Health of the 10 provinces reacted quickly and bitterly because they felt a decision had been made in the middle of negotiations that were progressing well. If they hadn't been progressing well, I don't think they would have been bitter. So we all assembled in Victoria during the election of 1975—I remember it very clearly because I almost had to lose my seat to go—where we discussed and had unanimous provincial agreement that the federal scheme was both arbitrary and unfair to cap the program suddenly.

It was a program they had been very proud of. Not long after that the federal government added another complication by using its right under the hospital care program to say it would terminate by 1981; they gave a five-year notice, I think, in the spring of 1976. I think this is all historically correct.

So in effect, the federal government had given notice that it was going to opt out of the two major cost-sharing components. Their reasons were simple, and there are documented speeches giving them. I don't need to go into them. Mr. Lalonde had made speeches right across Canada in the summer and fall of 1975 saying the provinces were wasting health-care dollars, that there had to be steps taken to find alternative lower-cost ways of delivering the health-care system, that the federal government couldn't continue on a cost-shared basis; there had to be some incentive for the provinces to manage the programs better and use the health facilities better.

Strangely enough, Ontario agreed with all these things. If you go back historically you don't find us at any point having said they weren't right, because they were basically saying what we had been asking them to do. So some time after I left the Ministry of Health a new program called existing program financing was drawn up, I am sure you are familiar with that, where a combination of tax points and cash, cash that was escalated—don't ask me to describe it—on a three-year moving average of the GNP—is that right, Sean?—were assigned to the provinces unconditionally to cover the previous health cost-shared programs and post-secondary programs lumped together.

In the last few months a number of accusations have been made by Madame Begin saying Ontario and other provinces are salting away dollars intended for health care.

I think that's where the substance comes apart. The moneys were made unconditional in order to give the provinces the flexibility to arrange the health-care programs in more efficient ways, covering services that were previously uninsured—like ambulances and things of that nature, like nursing homes which were put in at the last second on a per capita basis. The very success of the program is what they are now complaining about. The provinces are free to put the money into the consolidated revenue fund and they must maintain the programs.

We feel, and there is a lot of disagreement on this, that all the provinces have used the health dollars wisely and that the comments being made by Madame Begin really are raised in the heat of an election. She is saying

we are doing exactly what Mr. Lalonde told us to do in 1975, and blaming us for doing it. Again, the documents will all support this. We could quote him chapter and verse and we could quote her in return.

At the time the EPF was started, I am told that 68.1 per cent of the moneys flowed to health in the old formulae. We have used that percentage as the figure to calculate how much could be coming to Ontario for health. And apart from some bookkeeping arguments, we would say, in round figures, about \$2 billion comes to Ontario. You had a figure, Mr. McClellan, of \$2,324,000,000?

**Mr. McClellan:** Yes, \$2,324,800,000.

**Hon. F. S. Miller:** Yes, I could show you how that was derived and I could show you why we could take minor exception to it because they have included some revenue guarantee money in there that never was related to Health. And they have included moneys for the ComSoc programs as well as the Health programs in that figure. But apart from that, \$2 billion to \$2.3 billion would be the range we would argue in.

So we get about \$2 billion a year unconditionally from the federal government—

**Mr. McClellan:** That's the amount that is in dispute, I think.

**Hon. F. S. Miller:** Oh, no argument. As I say, I can spell out exactly where that difference occurs and I'll be glad to do it for you before I'm through today. We get about \$2 billion from the federal government which we would say is aimed at health care, we collect about \$1 billion from OHIP premiums, and we spend about \$4 billion—\$4,186,000,000 I think—on health care.

So after looking at all the sources of money that are given to us for health care, the province still raises well over \$1 billion of its own money on its own tax base each year to put into the health budget, even if all these moneys are properly coming to health. I think that is an important message because there were implications there that somehow we were making "a profit" on the transfers.

The second thing I would point out is that the \$2 billion which flows from the federal government to Ontario comes from their taxing resources and really all comes from the general tax bases of the federal government in Ontario. That is, I think, a safe statement to make because for every dollar raised in Ontario by the federal government, I think something around 66 cents comes back to Ontario. In other words a lot of transfer payments go out to other provinces. So anything we get from the feds one

can be sure came from within the province in total dollars.

One of the things that got lost in the whole shuffle, and which I do not think Madame Begin has allowed for, is that when the general tax reforms of 1970-71 occurred, the federal government gave the provinces a revenue guarantee at the time. You may recall that. That was to allow for a floor of revenue, should the income tax on the new sources not pay off as predicted.

They did not. So by 1976 we were getting about \$455 million from the federal government on that revenue guarantee. It was not aimed at health; it was aimed at the general revenues of the province. When the federal government put the EPF in they also took the revenue guarantee out, if you recall, and then amended it. So today we would say about \$200 million comes in on the revenue guarantee, against about \$455 million some three or four years ago. So there was a bit of sleight-of-hand in that process which left Mr. McKeough in one year in very dire straits because he lost that whole \$450 million of predicted revenue.

**Mr. Laughren:** That was the year he went to Edmonton.

**Hon. F. S. Miller:** I do not know which year it was but it was not a happy circumstance.

That really brings the story up to date except to say that when the federal government departed from the tax points Ontario wanted to get—we wanted something like 17 or 18 points, as I recall, back in 1974-75—was it 20 points?—okay—when they departed from the tax points and gave us half escalated cash and half—roughly—tax points, they assumed tax revenues would move up very quickly. Do not forget they were dealing in a day and age when revenues were. They have not, because of indexation of personal income tax. The cash side has gone up faster. Their increases to us have averaged out, I think, at 6.85 per cent a year over those years. If my experts want to correct me they are welcome to.

**Mr. McClellan:** Is that the cash?

**Hon. F. S. Miller:** That is the total amount—the total transfers.

Let me try to explain the difference you were talking about. I think I have a sheet of paper here with it.

**Mr. McClellan:** I was the one who raised the question. That goes to the heart of the matter, as far as I am concerned, because there is a spread between your calculation of entitlement—which you have suggested



was in the vicinity of \$2 billion—and the federal government's calculation of Ontario's health entitlement, which they have told us is \$2,324,800,000. So we have a spread of something in the order of \$300 million. I would like to have it accounted for.

**Hon. F. S. Miller:** Let me try and tell you what that accounting is, and I can even give you a piece of paper, if necessary, later on, so you can restudy it.

**Mr. McClellan:** I am sure it would be helpful.

[4:15]

**Hon. F. S. Miller:** Currently the income tax transfers for the EPF are \$1,271,600,000. The EPF cash transfer is \$1,833,900,00. That totals \$3,105,500,000. We take the 68.1 per cent that we have used as a factor throughout for health's prorated share, and that is \$2,114,700,000, add to that the \$20 per capita for nursing home care, extended care, which has been escalated, and that is \$210 million, and you would have their figure of \$2,324,700,000.

We would take away from that—this may be an academic argument, but I think at least we should see where we got our figures from—the \$210 million of revenue guarantees. That is not the \$210 million I just mentioned; they are two different \$210 millions. The \$210 million of revenue guarantee money that the feds have used—and revenue guarantees were never intended for health care—and take 68.1 per cent of that, since that is all they apportion to it, that is \$143 million.

**Mr. Laughren:** The \$210 million, is that the money that you said was designed for ComSoc purposes?

**Hon. F. S. Miller:** No, no. I will get to the next one.

The old revenue guarantee agreement that was in effect up till 1976 was bringing us \$455 million unrelated to health care, that was just for general revenue. That was replaced by a new formula—Hank can tell me—one point of tax?

**Mr. Ploeger:** Plus cash.

**Hon. F. S. Miller:** Plus cash, which currently is worth \$210 million. That was also for general purposes, but conveniently the feds have added it into this calculation.

**Mr. Laughren:** For health?

**Hon. F. S. Miller:** Yes. They said that must go for health.

**Mr. Sweeney:** Conveniently? Understandably.

**Hon. F. S. Miller:** It wasn't for health.

**Mr. Sweeney:** If you go back to 1971, when you were talking about your two major programs, health and post-secondary education, that is why the floor was put in.

**Hon. F. S. Miller:** No, no. The \$455 million of revenue guarantees in those days had nothing to do with the health and post-secondary programs. The EPF did. That was an entirely different calculation. That is why I am saying we feel quite justified in removing this \$210 million. Why not? If I was getting money for general revenue in any other way, you wouldn't—

**Mr. Sweeney:** The original transfer of tax points and the guarantee that you are going to get so much out of those tax points was tied into these programs. That is where the floor comes from.

**Hon. F. S. Miller:** No. You are confusing two programs, that is all I am trying to tell you. They have taken the EPF program, which I am giving you, and added to it some moneys that don't belong to it and saying they do.

**Mr. Laughren:** You will never win the shell game with Frank Miller. There is no pea under any of them.

**Mr. Sweeney:** That is why I say it is understandable why the feds would do what they do.

**Hon. F. S. Miller:** No, it isn't. Sixty-eight-point-one per cent of \$210 million we deducted, that is \$143 million, and the second \$210 million was for extended care.

**Mr. McClellan:** Can I stop you? I am just trying to understand you, Frank. You originally were getting \$455 million through the revenue guarantee.

**Hon. F. S. Miller:** Yes.

**Mr. McClellan:** That was cut down arbitrarily, from your point of view, to \$210 million?

**Hon. F. S. Miller:** It really went out of sight for a while and then came back to \$210 million. That was unrelated to health care and that is the point I was trying to make with my colleague over here.

**Mr. McClellan:** Yes, I understand that. Where you have lost me is why you are taking 68 per cent of that and deducting it from your health care.

**Hon. F. S. Miller:** Because Madame Begin had it in her figures.

**Mr. McClellan:** Where?

**Hon. F. S. Miller:** In the figures she gave you, the \$3,105,500,000 that I gave you in the beginning, she included that \$210 million.



**Mr. McClellan:** Under tax transfers?

**Hon. F. S. Miller:** Yes. They had it in those figures; we can show you that again in detail if you need to see it.

**Mr. McClellan:** I would like to see that, yes.

**Hon. F. S. Miller:** Fair enough. It is open to be seen, and rather than be confused by oral figures, you need to have them in front of you, I agree.

**Mr. McClellan:** Yes.

**Hon. F. S. Miller:** Do you want the sheets? We will wave the magic wand.

**Mr. Kennedy:** Are they available?

**Hon. F. S. Miller:** I kept them here in case you wanted them. I will give you another sheet right now, Ross, so we can compare some figures. We'll have that in two minutes.

**Mr. Sweeney:** We've got two different sheets.

**Mr. Blundy:** I've got one sheet, and John has another sheet.

**Hon. F. S. Miller:** We have three sheets altogether, which I'll be passing out.

**Mr. Blundy:** So we're supposed to have three sheets?

**Mrs. Campbell:** We have one.

**Hon. F. S. Miller:** Yes, but I want to get them out in order, if I may.

**Mrs. Campbell:** They've taken the one away from me and given me this.

**Mr. Blundy:** What does EPF stand for?

**Hon. F. S. Miller:** Existing program financing.

**Mrs. Campbell:** Can I get the three pages?

**Mr. Chairman:** Yes. The three pages will undoubtedly come.

**Mrs. Campbell:** They gave me one, took one away and gave me one. I still only have one.

**Hon. F. S. Miller:** Pardon me. EPF stands for established program financing.

**Mrs. Campbell:** No wonder you're having problems with your calculations. You can't get three sheets out of it.

**Hon. F. S. Miller:** I'm not having trouble with them. But I'm having trouble explaining them.

Interjections.

**Mrs. Campbell:** That's what you call planning around here.

**Hon. F. S. Miller:** At least you must admit that we had the sheets typed.

**Mrs. Campbell:** They give us one sheet, take it away and say we've got three.

**Mr. Chairman:** Have all members got three sheets?

Interjections.

**Mrs. Campbell:** Is that three now?

**An hon. member:** They're all different.

**Hon. F. S. Miller:** The one I was talking from was headed "Federal 'Health' Transfer Figure of \$2,324,700,000 for 1979-80." Mr. McClellan had asked me where that \$210 million got buried in that figure.

If you look at the sheet entitled "Cash Flow of Relevant Federal Transfers," which has a series of columns for different years, you'll notice under 1979-80 a listing of our anticipated revenues, starting under "EPF," from income tax and cash transfer. Those are the moneys that flow from the agreement of 1977.

Below that, we have a figure for hospital insurance, which is a flow from settlements of previous years and has nothing to do with this year's budget at all. Under "Old Revenue Guarantee," there is a figure of \$5 million, which is settlements from many years back—from 1976 or before. That \$35 million I'm going to be removing from my figures.

Down below it are the figures of \$87.4 million and \$122.2 million, which flow from the new revenue guarantee agreement. The total is \$3,140.05 million for that column, less \$35 million. Those two figures I said stem from previous years' settlements. That gives you \$3,105.5 million, which is the figure you'll notice on the page, "Federal 'Health' Transfer Figure," that we started with. The only figures we deleted were the \$35 million from previous years' settlements for moneys already spent.

It does include the combination of those two bottom figures, \$87.4 million and \$122.2 million, which in round figures is \$210 million. They counted them as health moneys, when in fact they weren't. And that was the argument we were taking.

On that first page, entitled "Federal 'Health' Transfer Figure," we started to deduct two figures we thought didn't belong—68.1 per cent of the \$210 million, which was included for revenue guarantees and 75 per cent of the extended care spending, since that is spent in another ministry. That goes through ComSoc. That's my understanding, 75 per cent of that figure is spent by that ministry.

We can safely take \$300.7 million off the \$2,324.7 figure and say those are the moneys that we would currently say are our share of federal transfers that are related to health care spending. That explains, I think, the

difference between the federal figure and the one we would be using. Below that we show the Ministry of Health budget is \$4,183 million and the total transfer of federal moneys is in the range of 48 per cent of the total health budget right now.

I would rather answer questions than carry on, because the recitation of figures is not easy to follow without somebody asking specifics.

**Mr. McClellan:** The difficulty is in reconciling different methods of accounting. The federal government seems to use a different set of categories in describing its transfer payments to Ontario within its own estimates procedures.

The Treasury Board estimates for 1979-80, which we obtained from the federal government, through the director of health insurance in Health and Welfare Canada, chose a different way of setting out these transfer payments for 1979-80 than that which the Treasurer has presented. I'm not sure I can do anything other than to describe to him the way they've set them out.

**Hon. F. S. Miller:** I'm not sure I'd necessarily understand them if you did. I think I would probably have to have staff look them over and reconcile them, if that's possible.

**Mr. McClellan:** Let me just show you the way they set them out, as they presented them to us.

They have two categories of transfer payments—cash grants and the tax points. They use those two basic categories, just as you do. However, within the cash grants category, in the Treasury Board estimates, the cash grants to Ontario are broken down as follows: hospital insurance, \$928.7 million; medicare, \$320.1 million; extended health care, \$210 million. They have a commonality with respect to extended health care but not with respect to the other two items. Those figures total \$1,458.8 million. That's what is shown as the cash grants transfer for health—\$1,458.8 million.

[4:30]

The second component shown in the federal data is the health component of the income tax transfer. The total value of the tax transfer is \$1,271.9 billion, and 68 per cent of that is \$866 million. So we have the health component of the tax transfer shown in the federal estimates as \$866 million for a grand total, believe it or not, of \$2,324.8 million. I don't understand how the two levels of government can be using such radically different ways of computing the same bucks.

**Hon. F. S. Miller:** First of all, any decision

to assign what has become a basically unconditional transfer to specific uses requires you to go back to some kind of base line.

**Mr. McClellan:** The base line, with respect, is the convention that you seem to have conceded, that you will take 68.1 per cent of health costs in the base year as the way of apportioning the tax transfer payments.

**Hon. F. S. Miller:** We agree that if you're trying to find out what's happened to the flows of moneys, the only benchmark we have is what percentage of the moneys were health when this formula started and what were post-secondary education and you assume they remain constant throughout. But, that's not a good assumption because once they freed them up from being conditional grants, they really were saying to the provinces, "You can use them according to your priorities. If post-secondary should get more, fine."

**Mrs. Campbell:** That's the point.

**Mr. McClellan:** That's precisely the question that I'm raising. Is Ontario saying that they don't operate on the convention of apportioning 68 per cent of those tax transfer dollars to health, or has Ontario changed the rules and is apportioning a smaller proportion of the tax transfer dollars?

**Hon. F. S. Miller:** Let me say this. If we went to a municipality that is currently getting an unconditional grant from Ontario for any purpose—we have \$510 million of unconditional grants flowing into municipalities—we could say that they have replaced what were previously conditional grants of such and such a type, therefore, they should be spending money on a particular program. The very reason for making them unconditional is so that decision could be made at another level of government.

**Mr. Laughren:** Then they'll answer to their constituents if they fail to deliver the service.

**Hon. F. S. Miller:** Yes, exactly. That's perfectly correct and I have to accept that responsibility in this argument.

Since we now have funds which flow to us that are no longer cost-shared and, therefore, unconditional in that sense, we have to decide how much money to spend on those programs without really relating it to the income any more. We must say, "What do we have to spend on health care in Ontario to produce the level of service we believe is necessary," regardless of whether it's 40 per cent or 60 per cent of this figure that we use.

**Mr. McClellan:** All I'm trying to establish is, has Ontario come to a policy decision that it is not holding to the 68 per cent split? My reading of the data, to the extent it is com-



prehensible, is that you've altered the 68 per cent formula so you're receiving more money from the feds but you're not taking 68 per cent of that and allocating it into health.

**Hon. F. S. Miller:** Ross, if the only moneys I spent on health care in Ontario were the moneys that could be tied down, the 68 per cent of this figure, plus the OHIP fees, then we'd be spending a lot less on health care. We're spending that 68 per cent plus \$1 billion from OHIP premiums, plus \$1 billion from general revenues. That's the point I'm trying to make; regardless of the sources, we're spending more than the assigned moneys.

I'd like to turn the question right around and say, "How do I, as Treasurer, treat it?" I think that's the important one. The Minister of Health and I have, I hope, the same point of view. He would tell you he always needs more money and that's natural. There are 22 other ministers who say the same thing. But, the treasury now can count on a flow of \$3 billion, in round figures, from the federal government under EPF, right?

**Mr. McClellan:** Yes.

**Hon. F. S. Miller:** That goes into the consolidated revenue fund. It's a source of revenue, just as sales tax or the provincial income tax is. When I sit down at the beginning of the year I know we can count on that money coming in.

**Mr. Laughren:** May I interject here? There is a premise, though, on which federal government grants are provided to the province, and that premise is that there will be a certain level of health care provided in the province of Ontario.

**Hon. F. S. Miller:** Right.

**Mr. Laughren:** When you renege on that then you can't say that—

**Hon. F. S. Miller:** That, of course, is where we would disagree in terms of whether we have reneged or not. That is what I was trying to come around to.

The second aspect of this is for the Minister of Health, in the budget process, to tell us what moneys are needed to run the ministry, as all ministries must do, and for us to tote those up and compare them to our estimated sources of revenue. At that point every year, every Treasurer has to go back to ministries and say: "Please re-examine it, because our tentative allocation to you is X billions of dollars." It hasn't anything to do with that source of revenue. We're now looking at what's needed to sustain the system.

**Mr. McClellan:** That's one way of looking at it.

**Hon. F. S. Miller:** That is the way one looks at moneys when they're unconditionally transferred. One gets the money. One must run the health program.

**Mr. Laughren:** But you would sure scream if they cut back their revenues and you'd be quite happy to blame the feds if they hadn't increased the contribution to the province. You'd be blaming them, not defending yourself.

**Hon. F. S. Miller:** I'm not trying to blame them. I'm trying to explain today. That's all I'm trying to do. All I can tell you is that when they made this program back in 1977, they thought they had pulled off the smartest move in history. They thought they had really capped their sharing of health care costs and had brought it into some semblance of order, because they were looking at an escalating rate that was very high. Currently, they're saying: "Hey, our formula turned out to be pretty good for you fellows and, as such, we want to withdraw from it."

If you recall, last November they gave notice to the ministers of finance conference in Ottawa that they wished to cancel the EPF program. However, it is statutory and, since it is statutory, obviously all 10 provinces said, "No way. Just because you made a deal that turned out to be to the provinces' apparent advantage is no reason to renege on it." Had it gone the other way, had this sliding GNP not turned out to be reasonably generous, they could have been leaving us holding the bag, and would have. Nor would I have been angry if they had. In other words, the deal was made.

I'm only saying that now we have to set those moneys in the budgetary process that we believe are necessary to sustain a good health care system. That's the point in argument. Those number of dollars exceed any percentage you take of these plus OHIP. That's all.

**Mr. Chairman:** I would like to say to the committee that we are out of time. I realize that this is a very complex matter and there are a lot of questions, I'm sure. I wonder if I could make a suggestion to the committee? After having studied these figures, if the committee members feel there are still outstanding questions, I wonder if the Treasurer might possibly be able to return maybe Wednesday afternoon later on?

**Hon. F. S. Miller:** Gladly. As long as I have available time or I can adjust my timetable, yes, I would.



**Mr. McClellan:** Maybe we should leave it to the steering committee to try to work out.

**Mr. Chairman:** Thanks very much, Mr. Treasurer.

**Dr. Olsen,** director of outpatients at the Lakeshore Psychiatric Hospital. Dr. Olsen, do you have a statement? Welcome to our committee, first of all.

**Dr. Olsen:** Thank you. I think I'd like to clarify one point, in that I'm director of outpatient and community services section of the outpatients, and not the total outpatient population section.

**Mr. Chairman:** Fine, thank you.

**Dr. Olsen:** That's about 50 per cent of the total number.

**Mr. Leluk:** I only have three or four questions that I would like to ask, Mr. Chairman. Dr. Olsen, are you a member of the committee established to discuss new programs as well as the future of the present programs? You are. Who is represented on this committee? Can you give us the names of the people on this committee?

**Dr. Olsen:** The chairman is Dr. Pat Lynes. There is Mr. Al Whiting who is, I think, the deputy administrator at Mississauga Hospital; Kip Holloway, who is the director of the Peel Mental Hospital Association; Ollwyn Butchart who is a public health nurse from Etobicoke.

**Mr. Leluk:** Who is that from Etobicoke?

**Dr. Olsen:** Mrs. Ollwyn Butchart. She was here when Dr. Rzakdi was here. I can't remember all their names at the moment but there are representatives from Parkdale, Etobicoke, Mississauga and Peel anyway. They cover quite a wide range as far as occupations are concerned—social workers, public health nurse, occupational therapists.

**Mr. Leluk:** Do you have an opinion on the new programs which have been proposed and what is that opinion?

**Dr. Olsen:** I think they are quite sound proposals. I think they are going to take quite some time to implement and that is one of my chief concerns, in fact, the time factor. I really am concerned about it. There have been problems already and I don't know if I am being pessimistic but I would anticipate there would be further problems.

**Mr. Leluk:** Did the committee make any recommendation regarding your particular program and, if so, what was that recommendation and do you agree with it?

**Dr. Olsen:** It sounds a rather vague one to me. As far as the costing goes the \$1.3 million I understand is to be spent now for the programs that have been suggested, al-

though there is going to be, as I see it, some difficulty there because Etobicoke's proposal involves taking over the whole of the outpatient system as it stands now. This would mean, if it is going to get off the ground, they are going to need part of the \$1.6 million immediately. That is what my reasoning would tell me anyway.

**Mr. Lawlor:** I can't hear, Mr. Chairman.

**Dr. Olsen:** You didn't hear the last part? Well, Etobicoke has proposed that they take over the whole outpatient program, including behaviour therapy, the alcoholic unit, DARE, and the outpatient and community services. If all of that is to come out of the \$1.3 million, if it is going to get off the ground immediately, it just isn't possible, they are going to have to start digging into the \$1.6 million, I would say.

**Mr. McClellan:** You are referring to the mayor's task force?

**Dr. Olsen:** No. The Etobicoke committee was formed as a result of suggestions by the implementation committee that each region form a committee to develop a plan for community psychiatric facilities.

**Mr. McClellan:** Is this the Etobicoke Mental Health Service Agency steering committee, or is that something else?

**Dr. Olsen:** Well, I've got that report and they call themselves—now what do they call themselves? They don't call themselves anything. They report to the community subgroup. I think everybody give themselves different names.

**Mr. McClellan:** I am confused as to how many Etobicoke proposals there are.

**Mr. Duksza:** Dr. Olsen, you were referring to the government's proposal and the future of the outpatient services; you are not referring to the mayor's task force. You were saying it just couldn't be done under \$1.3 million. That's what you just said.

**Dr. Olsen:** Yes. I am not sure what constitutes the mayor's task force.

**Mr. Duksza:** You were not referring to that, you were referring to the government proposals, and what will happen when Lakeshore is closed and the future of the outpatient services.

**Dr. Olsen:** No, what I was referring to then was the proposal made by the Etobicoke subgroup as to what facilities should be developed in Etobicoke to replace the outpatients and that they came up with the suggestion they should take over.

**Mr. R. F. Johnston:** Who is "they?"

**Dr. Olsen:** The Etobicoke group.

**Mr. McClellan:** I finally figure it out. The group that you are talking about is the community subgroup on outpatient services of the Lakeshore Psychiatric Hospital in Etobicoke and their report was endorsed by the major's task force. That's the one that calls for a service agency to take over the outpatient services of Lakeshore Psychiatric Hospital with a—

**Dr. Olsen:** Because they would take over the alcoholic services, they suggest, in toto, not just for alcoholics in Etobicoke, but alcoholics from the whole of Mississauga, Peel and Metro Toronto.

**Mr. Kennedy:** I just wonder if you could explain to me, you mentioned something that is complex and confused. As I see it, if there is an outpatient program, let's take the alcoholic. As I understand, it is a physical movement of that program from its present physical location to some other location.

What else is involved? That seems to me relatively simple; there is an infusion of \$1.3 million for expanding outpatient programs in some manner or other. But could you explain where the difficulty would be in relocating the existing outpatient services? [4:45]

**Dr. Olsen:** The outpatient services aren't just the alcoholic services. There are 1,400 patients.

**Mr. Kennedy:** No, I know that. I just used one as an example.

**Dr. Olsen:** There are a lot of difficulties in moving services such as these into the community. There is a lot of opposition. For instance, Mississauga and Etobicoke don't even have boarding homes or group homes, let alone an alcoholic unit, a behaviour therapy unit or a community clinic.

**Mr. Kennedy:** Yes, but the program is going now at the Lakeshore Psychiatric Hospital. I understand this, it would mean the relocation of that operating base to somewhere else. Say it is 10,000 square feet; what are the complications in that?

**Dr. Olsen:** I think money is one of the major complications. I don't know if Dr. Maharaj mentioned it, but he has looked for a place he could rent. It would be a very expensive business. He was thinking of schools because, as I understand, under the bylaw they are institutions and he could possibly use one. But, as I understand it, it is a very expensive business.

**Mr. Kennedy:** I can see that. Maybe you can find space readily and maybe you can't. In fact, in his opening statement a couple

of weeks ago, the minister said that Lakeshore would be retained in the public domain and that the ministry would be looking at all kinds of locations and costing them against perhaps staying right where they are; that is right in Hansard. But there is no great amount of equipment to be moved, or complicated medical—

**Dr. Olsen:** No, you don't have to move equipment; you have to move people, which is more difficult.

**Mr. Kennedy:** I agree with that. I just wanted to have it somewhat clarified.

**Dr. Olsen:** It is getting a community to accept psychiatric patients into their midst, and that takes a lot of time and a lot of hard work.

**Mr. Kennedy:** Yes, I know, that is another part of the problem.

**Dr. Olsen:** I worked in British Columbia for three years in a mental health centre, and the mental health centre I worked in had been in operation for four years when I started to work there. We were still having difficulty in the community in getting people to accept the fact that psychiatric patients were living amongst them.

**Mr. Kennedy:** Yes, but that is apart from the relocation of what is there at Lakeshore now.

**Mr. McClellan:** I want to pursue this, if I may, Mr. Chairman. Maybe I could go back to the question of how much it would cost to maintain the existing Lakeshore Psychiatric Hospital outpatient programs intact.

We had testimony from the mayor's task force with respect to this Etobicoke proposal—the community subgroup's proposal—which they had endorsed. They gave us a sort of budget for the eight outpatient services, but they hadn't costed out the whole thing. They seemed to have stopped at the point when they reached \$1.6 million; they still didn't have a budget for the detox centre attached to the addiction program, and they didn't have a cost for the sheltered workshop.

Have you got a budget for what it would cost to maintain the entire range of outpatient services from Lakeshore Psychiatric Hospital intact?

**Dr. Olsen:** I have added up the figures from Etobicoke, and they come to about \$1.5 million on the sheet I've got here.

**Mr. McClellan:** But that doesn't include a budget for the detox centre.

**Dr. Olsen:** According to this, it says "approximately \$614,000 plus detox." But I understand from what Mrs. Butchart said,



although I don't think that was confirmed by the psychiatrists in Etobicoke, they were going to use a ward of Etobicoke General Hospital as a detox centre.

**Mr. McClellan:** That wasn't clear to me. I had assumed they would keep an inpatient facility with the unit on the Lakeshore grounds. That's different from your understanding of the proposal, is it?

**Dr. Olsen:** From what the Etobicoke group was saying, I understood it was hoping to have the detox centre actually at Etobicoke General.

**Mr. McClellan:** And the rest of the service on the grounds of Lakeshore Psychiatric.

**Dr. Olsen:** As far as the outpatients are concerned. Of course there's still—I think ComSoc looks after the retarded—

**Mr. McLellan:** Workshop, yes.

**Dr. Olsen:** And there are actually patients in the ward on the grounds and another ward of chronic patients too, who remain there at the moment. But what concerns me is that while these services are being built up, I wonder what's going to happen to the outpatient department now on the grounds if there is only \$2.9 million, and during this shift of the budget from one area to another. I am concerned the services are just not going to be there to meet the needs of the patients.

**Mr. McClellan:** During the transition period?

**Dr. Olsen:** Yes, Because there have already been problems.

**Mr. McClellan:** Could you give us some details about the kinds of problems that have been experienced? Try to be as specific as you can.

**Dr. Olsen:** This is something that happened recently. Money was given to Peel, which wasn't to do with the closure, so I was told—a proposal had been made last year and a request made for funds to further develop a centre that already exists in Peel. As soon as the funds were received by the directors of this service, they terminated staff from Lakeshore—that is, one nurse and one social worker who had been working there for two years. They gave them only two days' notice. They had been working with a group of schizophrenics for two years and you don't terminate with psychiatric patients in two days.

**Mr. McClellan:** Which one of the programs were those two people attached to who were fired?

**Dr. Olsen:** It was Peel Aftercare Resources.

**Mr. McClellan:** That's the group that received the money?

**Dr. Olsen:** Yes.

**Mr. McClellan:** Right. Which program were the Lakeshore staff working on—the two people who had been fired once the Peel aftercare services received the money?

**Dr. Olsen:** They were working in PAR. That's a clinic.

So the thing that concerns me is that as people get money, they seem to be overwhelmed with their own enthusiasm and feel that they can do it on their own. While that's something I would applaud, it doesn't work out in practice because the people who know the patients are best able to help.

**Mr. McClellan:** Are there other instances of difficulties that you could tell the committee about?

**Dr. Olsen:** That's the only one to date. Some other difficulties that might arise there also are that the patients who have been into any Ontario hospital are entitled to receive their medication free thereafter from an Ontario hospital. This is something that's causing problems at PAR at the moment. It's because the nurse and the social worker don't go there any longer—especially the nurse, who is very much involved with seeing the patients get their medication—there are a lot of difficulties. Psychiatric patients don't always keep appointments. They run out of medications. The patients turn up at odd times and the clinic is only available to them for three days a week so we get a lot of telephone calls to the outpatient service saying they have run out of meds. Then that involves a whole bunch of telephone calls again trying to sort it all out. It's quite a complicated business.

**Mr. McClellan:** What's happened with the behaviour therapy unit? Can you bring us up to date? We have had some testimony about a week and a half or two weeks ago with respect to the difficulty in that unit, the laying off of—

**Dr. Olsen:** I don't think anything has changed there that I am aware of.

**Mr. McClellan:** Is the director still there?

**Dr. Olsen:** Yes, he's still there.

**Mr. McClellan:** Are the volunteers still there?

**Dr. Olsen:** I am not quite sure. This is the time of year when he takes in new volunteers and starts training them, so I am not sure whether there has been a holdup there or whether he's continuing with the old group.



**Mr. McClellan:** There are no plans at this point to replace the four staff people who were laid off from that program?

**Dr. Olsen:** Not that I have heard.

**Mrs. Campbell:** How much money was allocated for this Peel operation?

**Dr. Olsen:** I think it's about—oh, PAR, the one I was mentioning?

**Mrs. Campbell:** Yes.

**Dr. Olsen:** I think it is in the region of \$35,000.

**Mrs. Campbell:** I see.

**Dr. Olsen:** It's part of, as I said, something that was requested last year and not associated with the Lakeshore closure, so I was told.

**Mrs. Campbell:** I see. It won't be part of either the \$1.6 million or the \$1.3 million.

**Dr. Olsen:** No.

**Mr. McClellan:** Just a final question with respect to the disposition of the alcohol treatment unit: I gather from what you've said that the disposition of that service is still fairly ambiguous.

**Dr. Olsen:** Oh, yes.

**Mr. McClellan:** What are your own preferences about maintaining that service intact? What should be done?

**Dr. Olsen:** It's a very difficult question to answer. A day program is fairly easy to arrange and to manage. I see no problem there. But a detoxification unit is a 24-hour emergency service basically. You get people brought there who are intoxicated, but they may not just be intoxicated, they may be injured, they may be suffering from a head injury; they may be schizophrenics or manic depressives. They're not just simply drunks.

When you're a psychiatrist dealing with people who are intoxicated, you feel you need to give them the full services that a general hospital would give them. I don't think personally that the unit can be left on the grounds, the detoxification unit. I think it needs to be attached to a hospital.

**Mr. Chairman:** Dr. Dukszta and then Mr. Lawlor.

**Mr. Dukszta:** Dr. Olsen, I am getting from what you are saying some expression of concern on your part that—I don't want to put words in your mouth—to remove the Lakeshore hospital without the provision of an extensive sub strata of outpatient services, we are taking a significant risk with existing services and patients.

**Dr. Olsen:** That is my opinion, yes.

**Mr. Dukszta:** How much of a risk are we taking?

**Dr. Olsen:** It depends what you mean by "risk"; risk to society, risk to the government, or risk to the patient?

**Mr. Dukszta:** We can live with the risk to the government.

**Dr. Olsen:** Risk to society: Let's look at the general population then. Ten per cent of the patients in my particular part of the outpatient service are on probation, and I would say probably another 10 per cent have a propensity for violence. A lot of them are reluctant to take medication in the first place and only take it when they have quite a trusting relationship with their therapist. I think there are risks. There might be difficulties in this area.

**Mr. Dukszta:** But in a strict sense the therapists would be the same, wouldn't they, or are you saying that the therapists are partially inpatient clinical staff? I'm not sure how the system works. I remember how it used to work in Queen Street. We had people who were strictly outpatient clinicians, but there was also a whole set of people who worked both ways, both inpatient and outpatient.

**Dr. Olsen:** We are separate from the inpatient service, unfortunately. My personal view is that continuity of care is the ideal form of delivering a health service, but Lakeshore works in a functional manner, so we are separate.

My concern is that when the therapists in the outpatient department now are replaced by therapists in, say, Peel, or wherever, there would be problems if it were done hurriedly, in an unco-ordinated manner.

**Mr. Dukszta:** Yes, Damocles' sword is hanging over it, so in fact everything has to be done in a month. It seems to be very difficult to get that point across in the committee because a number of professionals, and I am one of them, know that those things simply cannot be done within a month. It's a question of co-ordinating and planning, probably taking a couple of years.

**Dr. Olsen:** I would think, especially from my experiences in British Columbia, one should think in terms of years, certainly, rather than months.

[5:00]

**Mr. Dukszta:** That is my impression and one of the reasons I am bringing this up. Ms. McLaughlin welcomed, at least as a waking-up call, the closure of Lakeshore Psychiatric Hospital. Actually, she started bringing in so many provisions and riders that in effect she said virtually what you said, that it takes two or three years to plan

a comprehensive set of outpatient services. What is your own professional feeling about this linkage between hospital beds and outpatient services? I'm stimulated by what you said about the way you see continuity of care and the need for a very close linkage between the bed and the outpatient service. Could you elaborate on that, on what you mean by "continuity of care"?

**Dr. Olsen:** I'm speaking of my British Columbia experience, basically, I suppose. Vancouver and the lower mainland, also, were divided into small catchment areas with a population of about 50,000, with teams working in each. In Vancouver, the general hospitals accepted patients and on the lower mainland there was a hospital similar to Lakeshore, but much larger, in which there were teams. The psychiatrist was the chief link, basically, looking after patients when they relapsed and went into hospital, and also continuing to look after them when they were out in the community.

In addition to these community mental health clinics, there were also boarding homes developed all through the lower mainland. This, as I see it, will be one of the major difficulties, because Etobicoke and Mississauga and Peel do not have them. People are going to be congregated downtown.

It's very difficult to move care away from Queen Street to outlying hospitals, if the patients live downtown, as so many of them do.

**Mr. Duksza:** In a way, you are in agreement that a psychiatric bed in a psychiatric hospital, as much as we may not like the idea of large institutions, tends nevertheless to be a fulcrum of the delivery of community-based services.

**Dr. Olsen:** It does, yes.

**Mr. Duksza:** As you said—and I agree entirely—we take a very significant risk with the people who we are now maintaining out of that hospital, out of that bed, by dint of enormous effort and medication.

**Dr. Olsen:** Very often quite a lot of effort.

**Mr. Duksza:** That leads me to the next question. One of the dangers of coalescing those two hospitals into one and cutting off the fulcrum, which is Lakeshore, is that we in fact may produce a pressure for the beds in the Queen Street Mental Health Centre.

**Dr. Olsen:** I'm sure there will be. I don't see any way of avoiding it, as things are going at the moment.

**Mr. Duksza:** Do you care to comment on

exactly how many patients we are talking about? That is of some importance to the committee, I think.

**Dr. Olsen:** I think there are between 1,200 and 1,400 outpatients, for a start, who are actively involved in programs at Lakeshore. There are another 550 ex-patients who are in what are called homes for special care. That gives you a population of about 1,700.

**Mr. Duksza:** I asked you that because other people in the hospital have said there is also a whole group of people who are not kept on the books who come into hospitals and deal with the clinicians.

**Dr. Olsen:** Of course, I don't think the people in the homes for special care are counted in the statistics because they are mostly looked after by family practitioners, but when they relapse, as they do from time to time, then they have been readmitted to Lakeshore.

**Mr. Duksza:** You haven't really come to a figure, but you think that by closing Lakeshore many of them could be affected in terms of the fact that either there is no care or there is pressure on the beds when they have to be admitted. Do you care to say the potential number of people who would put extra pressure on the beds at Queen Street if Lakeshore is closed?

**Dr. Olsen:** The total number of patients, not just outpatients?

**Mr. Duksza:** There is now a major effort by the staff to keep people in the community. The moment some of the services are cut, a number of people will simply drift to a hospital and be admitted. Would you care to estimate the potential danger of this type of situation?

**Dr. Olsen:** It's very difficult to give you numbers.

**Mr. Duksza:** Oh, yes. But you have a real fear that this may happen if the services are cut.

**Dr. Olsen:** Yes. I know we deal with—how many do we deal with, four a week? I know our patient admissions at present constitute 20 per cent of all admissions at Lakeshore.

**Mr. Duksza:** Yes. That's a very important figure. This is what produces the pressure on a psychiatric hospital. If you stop some of the services the pressure will, in fact, be transplanted into admissions, direct admissions. That is really what I wanted to establish.

Do many of the people whom you follow



actually live in the vicinity of Lakeshore hospital at the moment?

**Dr. Olsen:** Yes, the majority do.

**Mr. Duksza:** The majority actually do?

**Dr. Olsen:** Well, it's not the majority; about 50 per cent, I suppose, in Etobicoke.

**Mr. Duksza:** Fifty per cent.

**Mr. Leluk:** How many from the Parkdale area?

**Dr. Olsen:** There are about 200 in the Parkdale area and 180 of them live in boarding homes. There again there are problems. Maybe I should talk about all the problems.

**Mr. Duksza:** Yes.

**Dr. Olsen:** Somebody has spoken about them already. There is no legislation covering the running of boarding houses, they are purely commercial enterprises; no social worker or nurse has the right to go in and see what their standards are; they do go in from time to time, but they don't have that right by law. We rely, I suppose, very largely on information we get from the patients about the food and the kind of care they are getting. The other thing that concerns me is the people running them have no experience with medication and yet they handle enormous quantities of drugs. It really boggles the mind when you think of it. But it must say something of dedication or intelligence that we don't have major mishaps in that area.

**Mrs. Campbell:** We've had some.

**Mr. Duksza:** I was interested to hear that because many people have said the majority of patients actually live in the Parkdale area. It is quite true that that's where the bulk of the boarding homes are and our next presentation today or tomorrow will, in fact, deal with this. But you are actually saying that almost 50 per cent of the patients you deal with—

**Dr. Olsen:** In the outpatient community service.

**Mr. Duksza:** —actually live around the Lakeshore.

**Dr. Olsen:** In Etobicoke, yes.

**Mr. Duksza:** One of the dangers is, of course, that people do tend to move to where the service is. Ultimately it is the long-term individual who does this; not all of course, because some of the people are presumably discharged. Then again they drift even further towards Queen Street.

Can I just ask one question in terms of costs? We have been saying very glibly in the committee that one-point-something million dollars will in effect provide all the

needed—\$1.6 million or \$1.3 million is it we are talking about?

**Mrs. Campbell:** \$1.3 million in new services, \$1.6 million in continuing services.

**Mr. Duksza:** Yes, that's two figures. The new services, of course, will have to be split between Peel and other places. In your opinion, Dr. Olsen, is that an adequate amount of money to support the existing services and build new ones?

**Dr. Olsen:** I don't see that it can be.

**Mr. Duksza:** I tend to agree with you.

**Dr. Olsen:** But I am not a financier.

**Mr. Duksza:** But you do have the experience, as we see here, to know how much it costs to keep an individual in the community. Do you think that this is, in fact, not only not enough but significantly not enough?

**Dr. Olsen:** It would seem to me that it's not enough.

**Mr. Lawlor:** I'll try to be brief. What is your future? Are you going over to the Queen Street?

**Dr. Olsen:** Yes.

**Mr. Lawlor:** Mr. McClellan has run through quite a number of the outpatient services. There are one or two I would like to review. The minister in his statement when this committee convened, quite ambiguously—vaguely—dealt, for instance, with the alcoholism treatment centre. He said he is going to give serious consideration to leaving it but he didn't commit himself one way or the other with respect to it. Mr. McClellan has asked you about the behaviour therapy and that's okay, I'll leave that alone because of time. How about speech therapy?

**Dr. Olsen:** In Etobicoke's proposal they were hoping they would take over the speech therapy unit too. It involves one therapist.

**Mr. Lawlor:** How about geriatric outpatient services?

**Dr. Olsen:** Currently the outpatient and community services have taken that over. Previously it was handled basically by the inpatient service, but two nurses have joined my staff and we are now looking after the geriatric outpatients.

**Mr. Lawlor:** A fair number of those geriatric outpatients certainly live in close proximity to the hospital.

**Dr. Olsen:** No, they mostly live in boarding homes in the Parkdale area.

**Mr. Lawlor:** The sheltered workshop situation, what is the position there? The suggestion through the mayor's task force is that it either remain where it is or be relo-



cated in an appropriate community location. Do you know of any appropriate community location for that particular service?

**Dr. Olsen:** No, it seems to work well where it is, in fact.

Interjection.

**Dr. Olsen:** That may be because the hospital was close by too.

**Mr. Lawlor:** I think those are all the questions I wish to ask.

**Mrs. Campbell:** You were speaking about the percentages of people living in Etobicoke. Could you break that down further and tell us how many of the people who are living in Etobicoke are in fact living in their own homes, as opposed to living in some kind of a community situation, such as Parkdale has?

**Dr. Olsen:** It's about 60 per cent. I'm speaking now about the outpatient community services, which is about 50 per cent. I don't know about the other programs. But in our program, I would say about two thirds are living with families.

**Mrs. Campbell:** Doesn't that in itself make a difference in the statistical evaluation since we don't have proper homes for these people even where they are now living, in Parkdale? In other words, when you're breaking it down as to where people live, if they are living with their families it's quite a different proposition from living in the community in a boarding home or something, which is a commercial operation and seems to be a money-maker as far as I can see.

**Dr. Olsen:** Yes, it seems to be, although as I said, the staff must be fairly dedicated, even though they are not experienced.

**Mrs. Campbell:** Could I ask you this final one: Prior to the announcement, did anyone from the ministry consult with you about any planning for the postwar effects of the Lakeshore closing?

**Dr. Olsen:** Oh, no.

**Mrs. Campbell:** Oh, no. Never. Thank you.

**Mr. R. F. Johnston:** Just a point of clarification, Mr. Chairman. You mentioned people living with families. Was that always their own families, or do you have a placement service with families in general?

**Dr. Olsen:** No, with their own families, that is.

**Mr. Chairman:** Thank you very much, Dr. Olsen. We appreciate your attendance and your ability to assist the committee.

Alderman Janet Howard is next. Alderman Howard, I'm a little uneasy with that

title. Do you prefer "alderman," "alderwoman" or "alderperson"?

**Alderman Howard:** I like "alderman"; it spreads confusion. I think that's really very valuable. People stop thinking aldermen are always men when they meet me.

**Mr. Chairman:** You're the envy of us all with that tan, I must say.

**Alderman Howard:** Thank you very much, I enjoyed getting it.

**Mr. Chairman:** I'm sure you did. We have some material from you, Alderman Howard. Do you wish to review it briefly with the committee?

**Alderman Howard:** Yes, I apologize for just having got it up here today. In any event, I certainly won't read it out; it's quite short. You'll notice that the major thing I've given you is a report prepared by the city's planning staff on housing for single people. I'm sure it's more than you ever wanted to know about housing for low-income single people, but on the other hand an aspect of this whole Lakeshore closing that has to be looked at in isolation is the affordability of the housing stock there is, quite apart from the therapeutic value of group homes.

[5:15]

The reason I'm saying this is I know that the Ministry of Health has committed itself to seeing to it that more group homes get funded but I think that's a drop in the bucket, for even though there is some progress on that front, what we have to recognize is that spread throughout the city there are people who have spent time in Ontario hospitals who are difficult people to house in any event. Partly because their behaviour is occasionally difficult and therefore they just can't live anywhere and partly because there is a straight affordability problem.

What's becoming more and more apparent to me is we can't look at what the Ministry of Health does in isolation from what ComSoc does. A point I make in my written presentation is it isn't fair to be cutting Ministry of Health budgets unless you're correspondingly increasing ComSoc budgets for the kinds of things that are going to help people in their communities. I don't see that increase and I'm really worried about that.

Some of the material that's in here about the rooming houses, particularly in Parkdale, is about places where people simply pay their rent and don't get meals and things like that. I know the question of boarding homes is being looked into by Metro coun-

cil—we've got a personal care bylaw coming up in the city of Toronto—but we're still not covering a large body of people who are simply weekly tenants in ordinary rooming houses that are drying up and going off the market or getting more expensive as the competition for those rooms increases.

I'm not seeing any statements coming out of the provincial government for any programs to increase provincial housing for low-income single people, with or without problems, and that seriously concerns me. It's never been a federal government priority. It's something the city of Toronto has fought for and we've been fairly successful. CMHC has co-operated with us in allowing us to provide rent supplement—well, you provide rent supplement too and certainly a lot of units for low-income single people. But that is again a drop in the bucket when we're talking about the rooming house market.

What I would appreciate is if you would, at your leisure, go over those figures and try to figure out what you are going to do for people's housing out of the tiny bit of money, the \$1.3 million, you're saving on Lakeshore. What are you going to be able to afford to do, once you're paying for the outpatient therapy and the active treatment programs, for people who aren't living there?

The final point I'd like to make before I invite questions about this is I'm obviously not suggesting that Ontario hospitals ought to serve as hotels for people. Nobody is suggesting this is a good way of housing people. However, a byproduct of older days of handling people with emotional problems has been that they were housed. If they are no longer going to be housed, we're putting an additional pressure on the market as they come into the communities.

Therefore, the strongest point I want to make is that there has to be a close liaison between the Ministry of Health and ComSoc and you don't cut one budget without expanding the other one accordingly. If you do things like that then it's getting cynical, it's not just returning people to the communities for their own good, it's simply cutting your Health ministry budgets and it's cutting them at people's expense.

There was another thing I wanted to speak to and that's something local about my ward. I'm a very active member of the board of directors of Nellie's Hostel. I go over to Nellie's Hostel fairly frequently. It's in my ward. It's close to where I live and I drop in there. I am appalled sometimes at the atmosphere in that house and what the staff have to put up with. The staff is mar-

vellous. It's underpaid and it's overworked and they're certainly prepared to put up with a certain component of residents who have acute emotional problems.

However, there comes a point when the whole atmosphere of that house gets unmanageable, and they have to try to get some of their residents committed or admitted briefly to general hospital psychiatric units. They don't like having to do that. They would prefer to be able to cope with them, but the numbers are swamping them. On a week-to-week basis the kind of people you get in a women's hostel changes a lot. Sometimes you get a whole lot of teenagers for some reason. Sometimes you get a whole lot of elderly women who have been recently released from mental hospitals. The police bring people they don't know what to do with.

Nellie's Hostel is a perfect example of where ComSoc and the Ministry of Health are not playing the kind of footsie they should be playing. Nellie's is having to raise funds from private corporations and things like that in order to keep up the kind of staffing that's absolutely necessary to provide a service for the kind of residents they're increasingly getting. Nellie's has already noticed this and so have the other hostels. I'm sure Mrs. Campbell, who has more hostels than that in her riding, has had reports of this.

You cannot consider the women's hostels a beds-for-the-night operation in a strict hotel sense. They're having to pick up a lot of the treatment function that Ontario hospitals have had. They're doing that in a really humane and enlightened fashion. I think they've got marvellous staff that do a good job towards doing it, but they're starving to death. They're being treated as a ComSoc operation, they're not being treated as partly the responsibility of the Ministry of Health, and that's not fair.

There are other operations like a thing called the Rooming House Tenant Project which was spawned by an organization called the Christian Resource Centre, also in my ward. Essentially they act as middlemen for absentee rooming house owners. They deal only with hard to house people. You have to be hard to house to live there, because you're an alcoholic, or have acute emotional problems, or both. Their three-year demonstration funding from the federal Department of National Health and Welfare is running out in October.

Those of us who are interested in that program have been scratching around to find out where to get permanent funding for



things like that. Which ComSoc budget, for instance, does that fit into? Who is saying, "We're going to keep people out of the chronic-care mental hospitals and so on by funding programs like this which work"?

We're seeing a really bleak picture. We're being told by everybody, "Don't place too much confidence in all this talk about keeping people out of hospitals because the front-end money isn't there." So, that's an experience everyone who's trying to work with people who've had stays in mental hospitals is encountering right now. That's an experience that's growing.

Your closing Lakeshore is having a ripple effect. Nellie's is seeing it already—

**Mrs. Campbell:** Don't talk about "your closing".

**Mr. McClellan:** The government is closing Lakeshore.

**Mrs. Campbell:** We're not. The government is closing Lakeshore.

**Alderman Howard:** The government is closing Lakeshore, okay. It's having a ripple effect already. I know one family doctor in my ward who was worried about a patient of his who was having an acute crisis. He was afraid she was suicidal. He was phoning psychiatric units in the general hospitals to get her placed. In one hospital in my ward he was told, "Look, if you really make an issue of this, I'll see to it that she gets admitted, but the nurses got themselves together and they're in revolt. They're saying we've got too many people who are too crazy and we can't cope with that right now."

That's what's happening. You have to be practically burning the place down or cutting your throat in front of somebody before you get admitted. The ComSoc budgets have to be increased all across the line so the Ministry of Health can cope with the budgets that it's allowing to be reduced. Having said that, I'm free to answer questions.

**Mr. McClellan:** I don't know whether it is available or not, but one of the things it would really be helpful to have, if it's possible to obtain directly or indirectly from the city, is a study of folks who are psychiatric patients in precisely these kinds of situations who are on the general welfare assistance caseload.

**Alderman Howard:** It wouldn't be obtainable per se. A lot of the people who are on the general welfare caseloads may have been patients some time back. But I would never encourage welfare to invade people's privacy to the extent of compiling that kind of profile on recipients who may be recovering from a mental illness.

**Mr. McClellan:** I wouldn't want any kind of a questionnaire that was intruding.

**Alderman Howard:** Exactly.

**Mr. McClellan:** I just wonder whether that kind of data is available.

**Alderman Howard:** I think they may have done some profiles, but I don't think you could get anything that would be absolutely accurate. What you'll get though is that there are a lot of people on the general welfare rolls who are considered difficult people in one way or another. They have a history of evictions, and if you broke those down you would find a great many of those people would have a history of being patients.

**Mr. McClellan:** Right. My concern is what Jan Dukstza refers to as the backwards being transferred from the institutions into the community and—

**Alderman Howard:** That's putting it absolutely—

**Mr. McClellan:** —the only agency that has a kind of a sustained contact, I suspect, is the Metro social services department, through its welfare visitors. I am sort of thinking out loud about how this very real and increasingly critical problem gets brought to the attention of the Ministry of Health and the Ministry of Community and Social Services with sufficient force that they are impelled to act.

I understand completely the concern you are raising with respect to the inadequacy of shelter allowance under either the General Welfare Assistance Act or the Family Benefits Act. That is an item that gets raised every year in the estimates debates, with as many illustrations of absurd anomalies as we can come forward with.

**Mrs. Campbell:** We haven't really won.

**Mr. McClellan:** Precisely. With the impact that you can see—that you are before us today with a description from the planning department of what it costs to live in the city and anybody can tell just at a glance that those real costs bear absolutely no relationship at all to the shelter allowances that are given under general welfare assistance or family benefits.

It is useful for us to be able to get this kind of material, if there is any way at all that the city representatives can extract from Metro social services whatever data is already available with respect to people in receipt of social assistance at the municipal level who have some kind of a relationship with a psychiatric facility. Without—and I want to echo what you said—the kind of snooping and



prying that a survey questionnaire would require, it would be helpful to pull existing data together and make it available to us.

**Alderman Howard:** There is one thing I could probably get for you. Nellie's is very careful about people's confidentiality; in fact, Nellie's board and staff have a committee that we call the "invasion of privacy committee" because we got furious that Metro social services was asking the staff to provide social insurance numbers. The board ordered the staff to stop taking them and let the chips fall where they might.

In any event, Nellie's does do profiles of their residents. They do not put names on them, but I mean they do some research, and possibly we could get you a microcosmic little profile of that, of what one women's hostel might have as a cross-section, because, after all, a great many of their residents are going to be on social assistance and certainly their per diem rate is paid for by welfare, anyway.

I should say, by the way, that keeping Metro social services at five per cent for the next year is possibly not the best thing to do when we are considering closing down Lakeshore. I think there are going to be some additional strains from that.

The other source of information that might be valuable—and believe me, I am going to be around here with some other people in my ward, beating on doors for opening up some budgets—is the Rooming House Tenant Project, whose federal funding runs out in October. That kind of program is essential from a couple of points of view. For one thing, when you get fairly disturbed people who can function in the community if they have some support for it, that kind of program serves a double function. It not only keeps them from having to be committed again, it also keeps communities from coming out with terrible backlashes and getting redneck responses.

You will find, for instance, when the Rooming House Tenant Project takes over a rooming house things quieten down from the point of view of the neighbours, and that works out very well. That is a reality we have to look at. I doubt that there is a person in this room who shares any of the fears and views of mental patients that one hears but, boy, you read the letters page of the Star sometime and it is pretty terrifying what can happen to those people.

So I wouldn't mind trying to gather some information from the Rooming House Tenant Project as to what percentages they might have of the people they are housing who have been admitted at one time or another,

and I would guess it is the overwhelming majority.

**Mr. McClellan:** Those of us who are from the city are acutely aware of the problems in Parkdale. Has the mayor's task force on bachelorettes made any recommendations with respect to further licensing of boarding homes in the Parkdale area?

**Alderman Howard:** Not in the sense that you are probably thinking of, as far as personal cares goes. We are not getting into the business of food being provided, and medication and so on. There is a group that is certainly looking at that at the Metro level, but, on the other hand, funding for things like that is not going to come out of our pockets particularly. That, again, is going to have to be a ComSoc initiative.

[5:30]

We certainly are happy to look at standards for things like that. The city has to strike a very careful balance. When we found that in order to encourage rooming houses to remain rooming houses, we got a bit lax, we had a few people burn to death, and that wasn't—

**Mrs. Campbell:** Yes we did.

**Alderman Howard:** Yes we did. And then we went as far as—in fact, if anything, we went to the other extreme for a while. We had rooming houses reducing occupancy so they wouldn't have to be licensed as rooming houses; we had all sorts of things happening. In fact, we drove a lot of rooming houses totally out of business.

Where does the balance lie? I mean, how far do we endanger people's lives by loosening up standards and how far do we endanger people's lives by having them sleep in the streets?

I think what we've got to have is some funding for things like Archway, for instance. I know Archway is being funded; we have to have more groups like that. We have to have funding from ComSoc, and I specify ComSoc because I think it's their moral responsibility, for groups like the Rooming House Tenant Project. We've got to use these community-based models to make sure that we don't get a whole lot of housing standards bylaws that are supposed to be insuring people's health and safety when it doesn't fit, when they have got other needs.

**Mrs. Campbell:** Is this the reason the city doesn't use its health bylaws for the psychiatric boarding houses in Parkdale? Your health inspectors can go into a location.

**Alderman Howard:** Yes.

**Mrs. Campbell:** Your other inspectors in

many cases cannot and yet you are not using your public health bylaws for the psychiatric rooming houses. Why not?

**Alderman Howard:** Actually we are. What we do is we make—

**Mrs. Campbell:** In many cases you are not.

**Alderman Howard:** You are talking about the Rhodes Avenue Nursing Home, I think.

**Mrs. Campbell:** No, I am not.

**Alderman Howard:** Because that's the one that people are demanding that we close down.

**Mrs. Campbell:** No, I am not. I am talking about Parkdale and the fire on King Street and all of the concerns that built out of that. I wrote to the mayor of Toronto and I wrote to Mr. Timbrell. The mayor says you are not enforcing your health bylaws in these places, and of course the Minister of Health says it's not his responsibility, it's yours. And I wonder why you are not. Because some people—

**Alderman Howard:** I am sorry, I cannot accept the across-the-board premise that our public health inspectors don't inspect. I happen to know they do.

**Mrs. Campbell:** I am not saying that they are not inspecting, I am saying that the mayor says you are not using the health bylaws for these places.

**Mr. Chairman:** Perhaps we can pursue that. Mr. McClellan, have you completed?

**Mr. McClellan:** Just one final point. What you are saying, Janet, is that, so I understand it, the \$1.3 million, however nice and cute that is, doesn't begin to deal with the problem of the housing needs of a large segment of the population that is traditionally serviced by mental health care institutions and services, and until that budget item gets into somebody's budget, we are going to continue to have the kinds of problems that we have been experiencing in Parkdale and other parts of the city.

**Alderman Howard:** I would go further than that. I would say \$1.3 million, even without the closing of Lakeshore, totally devoted to housing for low-income single people, particularly with problems, would be a drop in the bucket.

**Mr. R. F. Johnston:** None of the \$1.3 million is going to Parkdale and that should be cleared towards housing.

**Alderman Howard:** It could go to housing. You have therapy programs and all sorts of things that I can well understand would have to take precedence over the housing. But, I think housing is getting left out.

**Mrs. Campbell:** The other points that I am going to make about Nellie's and about Women in Transition and the others in my riding—Nellie's is not in my riding but the others are—

**Alderman Howard:** That's right.

**Mrs. Campbell:** —are that it seems to me what you find—and I would like to be corrected if I am wrong—in many cases, for instance with battered wives, is there is a trauma that doesn't relate to any previous history of any kind, but which may in turn cause an admission, because of the problem which has caused them to go into these places. So that I could understand that it is pretty hard to develop any sort of data on the whole situation apart from privacy implications altogether. Certainly these people are coping with some of the most difficult situations. Some of these cases at least—even if we have to go this route of segregating the Health situation from ComSoc—are falling between the two areas and not being addressed by anybody really. The allowances to these people are so small and certainly they are in some cases developing very severe psychiatric problems as a result of their experiences while they never had any history of it before. You are quite right about all of those places.

**Alderman Howard:** Not only do I know that's happening but bear in mind when women, for instance, leave their husbands and so on they have their own housing need. There is also a downward economic pressure that goes on to single-person housing and, for instance, a thing on quite another subject I have noticed, the issue of adult-only housing—discrimination against people with families. You get the phenomenon where middle-income people are occupying housing that would ordinarily be occupied by low-income people, not very good housing, because the landlord will rent it to them. Similarly you get middle-income people with problems that are a bit difficult who end up putting a downward pressure on housing that would be affordable by lower-income people living in what I think most of us might call flea pits.

**Mrs. Campbell:** Well, of course, non-profit housing is not assisting too well at this time either. There you have a lot of people who could live in the conventional market perhaps taking housing that is needed by others.

**Alderman Howard:** They would be paying market rent if they were.

**Mrs. Campbell:** Some of them are, but the point is they are paying very close to market rent.



**Alderman Howard:** Well sure, because our program is set up that way.

**Mrs. Campbell:** That's right.

**Alderman Howard:** It's a spectrum and it's meant to be.

**Mrs. Campbell:** But it's putting a pressure, too, on the persons in the lower income bracket.

**Alderman Howard:** I can't agree, but I think we might argue that at some point.

**Mr. Chairman:** Have you finished, Mrs. Campbell?

**Mrs. Campbell:** Yes, I have.

**Mr. Chairman:** Mr. Johnston.

**Mr. R. F. Johnston:** I don't know if it's worth going further in this. You have been talking about a number of community groups like Nellie's, et cetera, that are providing services which seem to be going across Health and Social Services boundaries as most of those distress kinds of organizations do. Do you have any other comments in general about the community mental health system in Metro at the moment from your experience as an alderman? How adequate do you see the mental health care backup service system at the moment?

**Alderman Howard:** I see it as really inadequate. When there was a planning committee set up to figure out the future of a site that was very foolishly expropriated some years ago, right near Regent Park, for a school which now won't be built, big meetings were held in Regent Park to see what kind of use that land should be put to. Curiously enough, Regent Park people, who are very sensitive about how people view them, themselves said, "One of our greatest needs is for people with emotional problems to have something to do." What they were talking about was day centres and that was something Regent Park people actually asked for.

Given their sensitivity about centralizing services around them, that surprised me a lot; but they were prepared to admit that they had an awful lot of disturbed people there who simply weren't being looked after. It surprised me that they would come out and say that. It's certainly something that the community group working on the future of that site has approached the Wellesley Hospital about. The Wellesley is keen to get some stuff off hospital grounds and into the community and people recognize that a need is right there. That's certainly one concrete example I know. People know this from the experience in their own families and from

neighbours and the organizations they belong to.

There's also the drifting factor. With the various things we've got, like the All Saints Church drop-in, and various drop-ins around the area—I know they and their street-workers, like Fred Victor Mission street-workers, are being hard put to it to keep shepherding people into programs basically to babysit them, because they're out there creating a lot of problems. Some of them are alcoholics—it's hard to separate alcohol-related from mental health-related problems. In fact, as Dr. Olsen before me was saying, from the hospital's end that's a problem. For instance, the fact that there are only six detox beds in the city of Toronto for women has created particular problems.

There are funny ways of doing things with "need" figures. You can say, "Since nobody is bringing us more than the six, we don't need more than six beds." The reason why people don't bring you more than the six is because they know there are only six. In any event, women who ought to be in detoxes, for instance, get taken off to the Clarke Institute and they get told by the Clarke, "Sorry, you're too disturbed for us." It's a mess.

People like the Christian Resource Centre and Nellie's end up bouncing these people around in taxis, with community policemen.

**Mr. R. F. Johnston:** What about the two hubs of the mental health support system in Toronto at the moment? Exclusive of Lakeshore they are the Clarke Institute and 999 Queen Street. We've heard already from them in the past. Can you give me your impression about how they relate to the community? What has been your experience, in terms of their ability to deal with this on-the-street situation?

**Alderman Howard:** The Clarke Institute absolutely cannot do that. I have had a couple of instances of people—one doctor and one person from, I believe, Nellie's, or maybe it was the Rooming House Tenant Project—being turned away from the Clarke Institute for being too crazy. That's true. That's what they were told. The Clarke can't handle that.

**Mrs. Campbell:** The courts have that experience with the Clarke too, or have had in the past.

**Alderman Howard:** When you've got people who've got mental problems compounded by social ones—bear in mind that psychiatry in a lot of cases is a pretty middle-class profession—and you add to that housing problems and so on, you're in a real mess. Unless you get some kind of integration about what you



do with people who are socially disadvantaged as well as emotionally disturbed as well as poor, you're going to end up dealing in crisis care, and that's much more expensive.

As far as 999 Queen Street is concerned, 999 has a really fine reputation for dealing with low-income people. I know a lot of my constituents who have been really badly burned by social workers. A lot of agencies would prefer to trust 999 to a lot of other places around.

I'm sure 999 has its warts, but certainly I've heard some good things said of it by a lot of people who have used its services.

**Mr. Leluk:** Have you visited the facility yourself?

**Alderman Howard:** Yes, I have. I think it was about four years ago.

**Mrs. Campbell:** The last time was when they were trying to save that old building.

**Alderman Howard:** That's true. But I had a different kind of tour of it at another time. I had explained to me the phasing-out of residential care. I've got to say I was a little concerned even then that pendulums can sometimes swing too far.

As a matter of fact, someone who is distantly related to me had this happen and I was at the time aware of it. I was worried about it. A man who had been in St. Thomas for 22 years on medication was dumped into a nursing home in Windsor near his sister, who was having her own problems at the time—after all those 22 years, just on welfare, and with no supervision. Considering that the man, before he had been committed and sometimes when he was allowed out, used to line the family up at knife-point when he didn't take his medication, I thought that really was swinging the pendulum too far, even way back then. It struck me as down-right dumping. It's a subject I've been following with some interest over the last four years.

**Mr. R. F. Johnston:** I'll have to get into the warts at Queen Street et al. I hate to blemish your image about this one.

You are saying that in spite of that good reputation, your experience at the other end is that agencies that are not designed specifically to handle psychiatric problems but come across them are running into pretty substantial loads right at the moment. I presume that means people who are not, for some reason or another, plugged into the after-care or preventive care structures that emanate from Queen Street at this point.

[5:45]

**Alderman Howard:** Yes. You see, the thing

is this. The agencies I deal with, or the programs I deal with would have people committed only as a last resort. I mean, they feel that part of their function is to help people, not get them committed—to, you know, sort of calm them down, do what they can. The trouble is the level of disturbance that they are having to deal with is greater and greater all the time and they just know that they are not geared up for keeping those people out of hospitals.

**Mr. R. F. Johnston:** They are going to general hospitals, I presume, now—the psychiatric wards of general hospitals?

**Alderman Howard:** Well, yes, but there is a problem there, too. In fact, I am getting more and more accounts of people either not being admitted or being kept overnight and released, so they wash right back up again from where they came from.

**Mr. Chairman:** Are you there?

**Mrs. Campbell:** I am getting that, too.

**Mr. R. F. Johnston:** Just to sum up then, as Mr. McClellan said about the \$1.3 million, you see no major advantages at all at this stage to closing Lakeshore and shifting people into the Queen Street load?

**Alderman Howard:** No. I think we have gone too far in closing down beds until we have some plans for how we are going to structure stuff in the community. I think it is better for people, maybe, to spend a few weeks longer in hospital where they are at least fed and kept warm than to be bounced out in search of some kind of a furnished room on incomes that can't afford them, or to be looking for a group home when there isn't one to refer them to. I think the better part of humanity, in that case, is to provide them with the necessities of life.

**Mrs. Campbell:** It is the same sort of experience we had when we had this great feeling that we didn't want to put alcoholics into jails, so we were going to have detox centres and we were going to have group homes. In my experience in my riding those are the first people who are begging to go back to jails so they will get cared for. There is no place else to go. That is planning around here and it is infuriating.

**Mr. Chairman:** Thank you very much, Alderman Howard.

**Mr. Lawlor:** I think you are the only person who might have convinced Nick Leluk as to the validity of the position and I think you have probably done it.

**Alderman Howard:** My goodness, thank you. I am flattered. I don't know Mr. Leluk, but I am flattered.

**Mr. Chairman:** Well, thank you very much, Alderman Howard. We appreciate your appearance.

The final witness who is supposed to come before us today is not going to appear today, but will appear tomorrow. I found out just a short time ago that Mr. Weatherup, couldn't be available today, and he and a group of his people, or those associated with him in a similar problem, will be appearing tomorrow. So, the committee is adjourned until—Mr. McClellan?

**Mr. McClellan:** A reminder: Could you prod Dr. Durost to provide the fire incident

reports from Queen Street? I gather those haven't been received yet. There was one other item that he was going to provide us with—I think it was a detailed breakdown of the staff transfers, by category, from Lakeshore to Queen Street; maybe a phone call might facilitate that.

**Mr. Chairman:** We will pursue that tomorrow, Mr. McClellan.

The committee is adjourned until tomorrow after routine proceedings. Thank you for your co-operation.

The committee adjourned at 5:48 p.m.

## SPEAKERS IN THIS ISSUE

---

Blundy, P. (Sarnia L)

Campbell, M. (St. George L)

Duksza, J. (Parkdale NDP)

Gaunt, M.; Chairman (Huron-Bruce L)

Johnston, R. F. (Scarborough West NDP)

Kennedy, R. D. (Mississauga South PC)

Laughren, F. (Nickel Belt NDP)

Lawlor, P. D. (Lakeshore NDP)

Leluk, N. G. (York West PC)

McClellan, R. (Bellwoods NDP)

Miller, Hon. F. S.; Treasurer, Minister of Economics (Muskoka PC)

Sweeney, J. (Kitchener-Wilmot L)

### Also taking part:

Howard, Ms. J., Alderman

McLaughlin, Ms. A., Executive Director, Mental Health Association of Metropolitan Toronto

Olsen, Dr. J., Director of Outpatients, Lakeshore Psychiatric Hospital

Ploeger, H. M., Director, Intergovernmental Finance and Grants Policy Branch,  
Ministry of Treasury and Economics











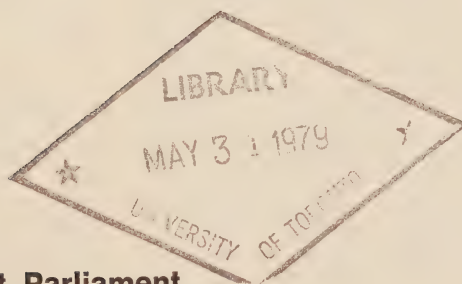
No. S-12

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Tuesday, May 8, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

## LEGISLATURE OF ONTARIO

---

TUESDAY, MAY 8, 1979

The committee met at 3:25 p.m.

### MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

(continued)

**Mr. Chairman:** We have a quorum and I believe we should commence our hearings for today. Mr. Lawlor, I believe you have a point.

**Mr. Lawlor:** I won't take very long. Doug Kennedy was going to report yesterday from the steering committee but was delayed. There's just one matter I wish to bring forward. We acceded to the Minister of Health (Mr. Timbrell) coming next Monday, but I put a condition upon it, if you recall, a fairly severe condition. Has anyone heard any reply from the ministry in this regard?

In other words, he was to appear tomorrow, Wednesday, and he asked not to appear tomorrow, would we rather accede to his request to have him appear on Monday; and I said, "Yes," but subject to certain understandings, upon which I won't elaborate. I don't wish to at this moment, it would take too much time. I would love a reply. I mean is this going to go by the board, and he's going to show up in any way he sees fit and without the condition being regarded?

**Mr. Kennedy:** I can make a call now and see what I can determine.

**Mr. Lawlor:** I would like to know.

**Mr. Chairman:** Mr. Lawlor, the chair's information is that the minister will be before the committee on Monday. That was the message conveyed to me. I didn't understand there were any conditions or strings attached to his appearance. All that was indicated was that he would be appearing with Dr. Lynes, I believe, and Mr. Jappy.

**Mr. Lawlor:** I think Mr. Kennedy will agree with me that there was a caveat connected with all that, wasn't there?

**Mr. Kennedy:** So far as you were concerned, you wanted them in a structured order of appearance; which I didn't agree to, or disagree with, I wanted to discuss it.

**Mr. Lawlor:** You're a strange man; you never say these things at the time.

**Mr. Kennedy:** Yes I do. Your hearing aid was turned down, Mr. Lawlor. How they come, or in what order, I don't think is too great an issue.

**Mr. Chairman:** Okay, can we proceed? Mr. McClellan?

**Mr. McClellan:** Were you able to make contact with Dr. Durost about those fire incidents?

[3:30]

**Mr. Chairman:** Dr. Surplis was supposed to get the information. It hasn't been conveyed to the chair as yet, but we'll keep pursuing it in your interest, Mr. McClellan.

The union is appearing before the committee today: Mr. Sean O'Flynn, the president of the Ontario Public Service Employees Union; Mr. Bob De Matteo, the researcher with the same union; Mr. George Sneyd, Mr. Sam Wood, and Mrs. Valentine.

**Mr. O'Flynn:** Before we start into our formal presentation I think it's profitable to make a point. There should be a very clear understanding of our motivation in making our presentation to you today. Of course we have a concern for jobs, but we also have a concern for the welfare of the total community. Indeed, this has been a tradition of the trade union movement and a concern of the trade union movement since the beginning of the trade union movement. I won't be able to go back that far, but I copied a page out of *The Trade Union Movement in Canada, 1827-1959*, and if we go back to 1891 we'll see that the central trade union body at the time, the Trades and Labour Council, met with the then Prime Minister, Sir John A. Macdonald, to present to him the trade union movement's legislative concerns. To show you how broad and all-encompassing they were, I'll read a few of them to you: "Free compulsory education, the eight-hour day, government inspection of all industry, public ownership of public utilities, abolition of child labour under 14, abolition of property qualifications in all public offices."

This has been the tradition of the labour movement, to be concerned about the welfare of the community as a whole and the quality of life in that community. It is in that context as well as a bargaining agent that

we appear before you today. I am glad to have this opportunity to present a case that questions the advisability of closing Lakeshore Psychiatric Hospital with respect to the maintenance of mental health services to the communities concerned.

On January 2, the Minister of Health announced that Lakeshore Psychiatric Hospital would be closed down by September 1 of this year. What is extremely disconcerting is the fact that there is little evidence that this decision was made with any extensive analysis in the form of a background policy paper that deals with the many problems that surround such a decision. In point of fact, the Minister of Health admitted to this very committee that no analysis was done prior to making the decision, and that no planning based on factual data was carried out with respect to developing viable alternatives in the mental health care network.

At the same time, however, the ministry had before it, for at least a year, an extensive study produced by the well-recognized McKinsey consulting company that made two central conclusions:

1. That Lakeshore Psychiatric Hospital provides essential mental health services not otherwise available.

2. That the area now served by Lakeshore will have the highest growth in demand for psychiatric services.

To quote the McKinsey report: "Psychiatric hospitals are an essential component of the overall psychiatric care system of greater Toronto, because they meet the treatment needs of a distinctive category of patients better than any alternative facility. Thus, we recommend that they not only be maintained, but given the operating funds needed to do an effective job.

"Lakeshore and Whitby should be fully renovated or, more likely, completely rebuilt. We believe it would be unwise to plan on a reduction in the rate of admissions to cut the growth in beds needed at any of the psychiatric hospitals, especially at Lakeshore."

That report recommended that Lakeshore hospital be maintained to meet the needs of the most rapidly growing area of greater Toronto. In recognition of some of the physical shortcomings of the hospital, it also recommended options for rectifying this:

1. A total rebuilding of the facility at an estimated cost of \$22 million; or 2. Extensive renovations.

McKinsey, however, did not maintain a rigid line with respect to either proposal. They left room for other less extensive options that included less costly phased-in partial

renovations. Yet in spite of this extensive fact-finding and analysis, the ministry went ahead with a decision which was absolutely contrary to the conclusions and recommendations of the McKinsey report.

What did the ministry base its decision upon? According to the minister, the decision was based on several isolated reports that he tabled with this committee which did not, however, address themselves to the factual analysis of the McKinsey investigation. Nor has the ministry developed a point by point refutation of the McKinsey study as a basis for the decision to close Lakeshore hospital.

I am sure the members of this committee share our misgivings about the lack of adequate study and an equal absence of systematic planning on a decision which has wide ramifications for the provision of mental health care in greater Toronto. What I should like to do today is deal with vital issues concerning the closure of Lakeshore. These issues include the following:

1. The capability of the Queen Street Mental Health Centre to cope with Lakeshore's current patient load and the future responsibility for the Lakeshore catchment area.

2. The viability of the minister's community based alternative for dealing with the needs of a combined catchment area and providing quality care.

3. The adequacy of Lakeshore's existing facilities with respect to safety and environmental quality.

Here with me to speak on each of these issues is George Sneyd, who is a psychologist at Queen Street Mental Health Centre. Irene Valentine is not available today. We have John Firth, who is the vice-president of our local at Lakeshore. We have Bob De Matteo, who's a staff member of OPSEU, and we have Sam Wood, who is the president of the Lakeshore local. First, I would like to turn to Bob De Matteo and George Sneyd, who will deal with the availability of Queen Street Mental Health Centre to cope with Lakeshore's current and future patient load.

Mr. De Matteo: We hold that Queen Street will be unable to absorb Lakeshore's current and future patient load and meet the needs of the Lakeshore catchment area. We are aware of the ministry's estimation of available space for beds, but an administrative estimate is not a suitable substitute for the clinical perspective of the professionally trained and those who have a day-to-day experience of the hospital's operation.



While it is true that Queen Street is able to physically—and I emphasize physically—absorb a portion of Lakeshore's current patient load, this will mean a disruption or disbandment of certain therapeutic programs now in operation at Queen Street. In order to demonstrate this to the committee, I would like to take the time to give a building-by-building review of what currently exists and how the ministry has proposed to make more beds available. At the same time, George Sneyd will comment on the impact of the ministry's proposal on programs and quality of care.

Now keep in mind that Queen Street consists of five buildings, the 1956 building which basically houses the psychogeriatrics unit and four towers. These four towers basically serve the several geographical areas of the Queen Street catchment area.

Starting with the Northern Services, you'll note, if we begin to look at the chart that I provided here, that on the fifth floor of that unit—let me say this, that each tower is practically identical in the kind of space that would be available for beds.

Also, if you look at the modality of treatment in those particular towers you note that the first floor is usually an assessment unit or an admission unit; it then goes gradually up, until eventually on the fifth floor there are usually daycare programs where patients are becoming cured, at least theoretically, and are then able to cope in a community atmosphere.

Anyway, let's look at what is available in Northern Services. Right now on the fifth floor, on the top floor of that building, there's a child and adolescent unit. There are 34 beds proposed. Keep in mind that each unit, from the second to the fifth floor of each tower, will have 34 beds as a maximum; that's the architect's estimate of what would be available. The first floor is usually a 14-bed unit, or has space available for a 14-bed unit. Each tower at maximum would be able to house 150 beds.

On the fifth floor of the Northern Services tower you currently have a child and adolescent program, which I believe is administered by ComSoc and is not part of the normal operation of the Ministry of Health. There are 34 patients—well I can't call them patients; but anyway 34 young adults in that particular facility. The plan that is proposed by the ministry is to relocate that particular facility as a child and adolescent unit operating out of Queen Street, or to relocate it someplace. They haven't determined exactly where that's going to be, but we would agree there would be 34 beds

available should they relocate that particular unit.

If we go now to the fourth floor, which is right underneath the fifth, there are currently 34 beds set up, a maximum of 34. In other words, it's reached its maximum, the figures I'm giving you right now on patient counts were done with the union along with the Director of Psychiatric Hospitals, Mr. Jappy. At the time of that particular count there were 42 patients on that particular ward.

**Mr. Lawlor:** What day was that?

**Mr. De Matteo:** That was, I believe, April 10. At that time there was an excess of eight patients. Now where do you put those other patients? Some patients were on leave of absence. Some patients were being guested in other wards, meaning they were taken from that particular acute ward and put in another ward. Again, the count could be different today; it changes from day to day.

On the third floor there is a vacant ward. We have no disagreement that as a matter of fact you could get 34 beds into that particular vacant ward.

On the second floor, and this is true for most of the towers, there is a long-term rehabilitation unit which basically deals with patients suffering from chronic disturbance. At the time of the tour of the building there were 43 patients on that 34-bed unit. Again, some of those patients were guested out to other wards which had beds available.

The first floor currently houses a daycare program. This is basically for former patients who would be on an outpatient basis with the hospital at this point and would come in for therapy, counselling, assessment. That unit also does some crisis intervention.

[3:45]

It is the union's position, based on discussion with Queen Street staff, that a maximum of only 51 beds can be set up as opposed to the ministry's estimate of 65, and this is based on the relocation. Mind you, we take into consideration that the child and adolescent unit would have to be relocated; however, we don't know where that's going to be.

We disagree with the erection of 14 beds at the expense of the daycare program, which would have to be—I guess it would be more proper, instead of the word "disbanded" to use the description "disbanded and relocated." The ministry has not yet found a suitable location. The daycare team itself, those people looking after that program, has rejected the proposal of the ministry to move that

particular facility into the basement. They don't feel that's an appropriate place for a daycare program, dealing with counselling and rehabilitation programs for outpatients; a basement is a basement. In spite of comments about windows, the only windows I saw in that basement existed in one room and they were simply skylights and that was it; otherwise you're dealing with a basement.

I might add, too, that there are classrooms there being used now for the children and adolescents.

Moving on to Southeastern Services, this is a similar program.

**Mr. O'Flynn:** Before you go on, Bob; George might like to speak to that issue of the daycare program.

**Mr. Sneyd:** Yes, I could speak a little to that. I don't work on Northern Services, I work on Southern Services, but I was talking with the treatment team which works on the daycare program on the first floor in Northern Services quite recently, yesterday afternoon as a matter of fact.

To support what Bob's been saying, they feel very strongly that the basement area is environmentally and structurally unsuitable for a daycare program. They've rejected trying to be placed in the basement area. They're trying to come up with other solutions so they can continue to look after their daycare caseload. The one recommendation they're making now is that they would become what's called a day-night hospital, which means the 14 beds would be used to sleep patients who are inpatients but who would be able to go out to work during the day, at which time the ward area itself would be used to set up activity programs for the daycare patient who would come in during the day while the nightcare patients were out.

They have misgivings about this proposal themselves, but they're trying to deal as best they can with the situation they're faced with.

**Mr. O'Flynn:** It reminds me of the old boarding houses in England where the night shift would get out of bed and then the other shift would take over. Carry on, Bob.

**Mr. De Matteo:** Okay. In Southeastern Services, servicing the southeastern portion of the catchment area, looking at the fifth floor there is a selfcare unit. A selfcare unit is basically for those patients who have come up to the top, who have been admitted to the hospital and have progressed through treatment and have been assessed to be able to be on minimal supervision and to care for themselves. The idea here is to minimize

the transition from inpatient status to eventual selfcare and aftercare, and eventually to outpatient status.

That's set up with 20 beds presently. The ministry proposes to expand the number of beds in that area to 34. There are currently 18 patients there, which means that—

**Mr. Sneyd:** Probably more than 20.

**Mr. De Matteo:** There are 20 today, okay; so the day I was there there were only 18, today there are 20. Okay, so we'll mark a zero there. Anyway, that program is rather important, particularly if one is talking about preparing patients for beginning to integrate into the community atmosphere again. If they don't get that preparation they become ill equipped to deal in a community setting. This prepares them to begin to do those things.

Keep in mind what a patient goes through. He almost has to rebuild his confidence in taking care of himself, in very simple kinds of activities. That's why this is set up in such a small scale rather than having a 34-bed unit.

On the next floor is an acute ward, but again that ward is tied in with the selfcare ward. Usually on a rotating basis, the acute ward will send patients to the fifth floor, to the selfcare unit, when they have been assessed to be able to cope with that kind of a situation. There were 34 beds set up. That is at a maximum; there are 33, maybe it has changed; George, is it still 33?

**Mr. Sneyd:** We're full; we're over our count.

**Mr. De Matteo:** Okay, so it's at 34 maximum. I should mark these down. The scoreboard is getting better. On the third floor there is a currently vacant ward. It's possible to set up 34 beds; there is no disagreement that can't happen. On the second floor, there is, again, a long-term chronic-care unit. It's got 34 beds set up, 34 maximum, and there are 32 patients. George, is there any change in it?

**Mr. Sneyd:** It's still about the same; there are 32 patients.

**Mr. De Matteo:** On the first floor is the crisis unit, a 14-bed unit. At the time we made our tour with Mr. Jappy there were only 10 patients in that particular unit; but keep in mind this is called a crisis unit, it's basically an admitting unit for the assessment of people who are directly admitted to the facility. These beds, however, have to be kept available for admissions, they can't be used for regular patients.



You can't simply take patients who are currently at Lakeshore and transfer them over. It is the union's position on the whole that only 39 beds; and I imagine we have to change this since it's all filled up in those two wards now so that only 36 extra beds might be available. The ministry's intention to set up 14 extra beds in the self-care unit would destroy the basic function of that self-care program.

Secondly, you cannot count on the four vacant beds in the crisis unit as available for regular patients. The crisis unit functions specifically for assessment of direct admissions. Perhaps George would speak to those two items.

**Mr. Sneyd:** Thank you. Actually, I am what is called a primary therapist. I have patients assigned to me, inpatients who are day-care patients—that is, patients who come in every day of the five-day week, some of them come in seven days a week—and I have outpatients on after care whom I see once a week or once every two weeks or once a month. I am the therapist who then has patients on both the fourth and fifth floors.

It's what we call an integrated program. We think there are a number of very good, positive qualities to that particular program, and one is the fact we have inpatients who progress slowly, improving in their behaviour, but still requiring hospitalization, although not intensive supervision in the form of night-care or evening-care nursing. We give them additional responsibilities and they then are transferred from the fourth floor, which is an inpatient treatment ward, to the fifth floor, which is what we call the self-care ward as Bob De Matteo was explaining.

The virtue of the self-care ward is the fact that patients assume responsibilities they don't normally have, yet they still have the support system of the hospital behind them. They begin to learn the skills of every day living again. They get up in the morning, they are not called by nurses; they manage their own medications, most of them; they are expected to attend group therapy or individual therapy sessions and are not programmed by the staff. It is their responsibility to live up to a contract they have established with their therapists and they have generally succeeded in functioning that way. But they still require, as I have said before, the support of the hospital prior to their moving out of hospital. This particular program will be completely scrapped as the result of transfer of patients from Lakeshore. The program planning committee that is working on Southeastern Services—because we have to, if this event occurs

—has decided that's one program that will go. The fifth floor will become, I guess, a short-term, inpatient treatment ward. We will no longer have the ability to use an area to gradually wean, if you will, a patient from the dependency on the institution into gaining further responsibility for himself and then placing him back into the community. That whole program will be scuttled.

That program has been in place for between three and four years now. There is a number of staff at Queen Street who have spent a lot of time working to put that program together, and it takes time to develop a strong team with very effective communication. That team will be broken up as a result of the transfer of Lakeshore staff and patients to Queen Street, because we have to assign staff to the vacant ward on three and to what will be an inpatient ward on five. So you might say in a lot of ways three to four years of work will be sort of down the drain as a result of the transfer of patients to Queen Street.

The only other thing regards the crisis unit which is called at Southeastern, the assessment and referral centre, the 14-bed ward on the first floor. You can't really count any empty beds there. You can't transfer people who are in an ongoing treatment program at Lakeshore and say, well, there are four empty beds right now as the sheets say we have; there are four empty beds on the crisis unit. I have worked on admissions and I know you can have four empty beds at four o'clock this afternoon and by eight o'clock this evening have six patients being admitted.

You cannot use a crisis intervention centre to house an inpatient population. So forget about any vacancy rates that might be available on a daily census because it varies so much from day to day.

**Mr. De Matteo:** We turn now to unit three which is a psychogeriatric unit and serves the whole catchment area; it's a functional unit. But the fifth and fourth floors of that particular unit are taken up at present, and will be in the future, by the METFORS program, which is a court referral and assessment program funded, I believe, by the Attorney General's office. It is basically used by the Clarke Institute for the assessment of court remands. So these beds are not available for regular hospital programs and the ministry understands this. There is no dispute about that.

On the third and second floor are the psychogeriatric units themselves. They have a 34-bed setup—that's a maximum—and there are 34 patients in each of those wards, so



there are no extra beds available there. The first floor currently houses some offices and the proposal of the ministry is to relocate those offices somewhere and set up a 14-bed unit on that floor. We see no problem with the 14 beds estimated for that tower. However, we would question where these present offices will be relocated, given the demand for space already.

If we turn now to Southwestern Services, again the same kind of program exists here. On the fifth floor there is a self-care ward, but I think one of the people who gave testimony here, I believe it was Dr. Wasylenko, talked about the revolving-door program at Queen Street. Well, that fifth floor is the revolving-door program at Queen Street. It is a self-care ward that deals with those patients who are frequently readmitted to the hospital—patients who leave the hospital but quickly break down again and are placed back in the hospital's care.

[4:00]

Again, the basic function of that particular unit is to minimize the difficulties of the transition from an inpatient status to outpatient status, and the ability of the patient to function well in the community. That is presently set up as a 20-bed facility; you can set up 34 beds there and there are currently 19 patients. I don't know if the status of that number has changed or not so there is, at present, one vacancy.

On the fourth and third floor, you have regular acute care wards. Presently there are 34 beds set up in each of those wards. On the fourth floor there are five vacancies and on the third floor there are 10 vacancies. I don't know if that status has been changed but in my discussion with the people who work on those particular units they point out that this fluctuates. At any one point in time we may find out that, yes, there are 29 patients on one ward and 24 in another. But next week this may change entirely, depending on the particular admission rate during that particular week. So we don't see that you can count on those vacancies, particularly when you're going to add to that the responsibility for another catchment area. Those vacancies are there for people coming from the Queen Street catchment area. You can't assume that this is excess space. It's not.

On the second floor is a long-term program for the chronically ill, people who don't respond well to various kinds of medication or to treatment, or those who suffer organic damage, mainly brain damage. This ward has only 20 beds, the reason being it also houses a day-care program that services the entire

Southwestern Services. A point to be noted is there are 20 beds set up but there is an excess of two patients on that ward. They are guested on other wards that might be free. But keep in mind that guesting means all of a sudden another staff may have to deal with a patient who is an unknown quantity.

In the crisis unit, the assessment unit, on the first floor there were seven patients at the time of this count. My discussion with the individual working on that service points out that 22 patients were identified as belonging to that unit at one point in time. That is more recently than the date I have here and they are guested on other wards. Also keep in mind that, when we are guesting patients from an admission ward, we are talking about a patient who is not known and when transferred to an acute ward usually requires more than 72 hours of treatment, or even more than that.

Again, guesting excess patients poses a hazard for those other patients; it overly stimulates patients who need peace and quiet. That, I think, is an important consideration.

It is the union's position that only 16 extra beds might be available in this particular service. First, one cannot count on the seven beds being available from the crisis unit for the reasons alluded to by Mr. Sneyd. Secondly, there are no extra beds on southwest two because of the excess space being taken up by a day-care program. I think we mentioned earlier the importance of a day-care program, in aiding the patient in that transition.

To increase this ward to 34 beds would mean this program would have to be scrapped. There are no extra beds possible on southwest five, which contains the revolving program, because of the nature of the self-care unit itself. Should extra beds be placed here, this program would also be destroyed. I might add that Dr. Wasylenko pointed out that the Clarke used that particular program quite frequently and had a lot of good things to say about that program.

We move to the 1956 geriatric building, and the only part of that particular building which is used to treat patients is the third floor. Right now there are 34 beds set up. The ministry feels there should be 50 beds set up in that particular unit. There are currently 34 patients—right now they are filled up—which would leave an excess; in other words, the ministry's proposal would leave an excess of 32 beds.

It is the union's position that, clinically, no extra beds would be available. It is too bad that Mrs. Valentine could not be here to speak to this issue; she is the head nurse on that particular ward. However, I am conveying the thoughts that she had with respect to expanding that unit. Making these beds available would mean converting the present dining room on the ward to a bedroom—the patients would be denied the present dining room they have—and disbanding the present psychogeriatric day-care programs, which sits between the two geriatric wards on that particular floor. It would mean disbanding that and relocating it somewhere else.

The important thing to realize when we are talking about all these excess beds is that, even if this space were available on this particular ward, they would have to be exclusively used for psychogeriatric patients; they wouldn't be suitable for any of the patients slated for transfer from Lakeshore. Keep in mind that psychogeriatric patients have already been transferred to Queen Street.

The only reason we could think of why the ministry wanted to expand these beds was perhaps to develop the old back ward. A back ward was the dumping ground for those you wanted to hide from public sight. Perhaps they also want to throw into that particular psychogeriatric ward the organically brain-damaged and so on.

While the ministry estimates there is space for 217 additional beds, that is based on the discussions we had with the ministry at that particular point in time. I understand it has changed somewhat, although not significantly, so that there is space for 200 additional beds to accommodate the rest of Lakeshore's 151 patients slated to be transferred. At that time there were 151 patients, although Mr. Jappy said there were 146. We found that he didn't count a few people who happened to be on leave; when patients are on leave, beds are saved for them so they can come back to them.

Although they have come up with that particular estimate, the union estimates there are only 120 extra beds clinically—and we underline that—available, leaving a shortage of 31 beds to deal with that particular load of patients.

This presupposes that a number of programs, along with their patients, are not being transferred to Queen Street from Lakeshore. We have been told that the addiction services unit and SOC may not be transferred. We have heard rumours that ward B from Lakeshore may not be trans-

ferred. The child and adolescent unit would probably stay where it is, or be relocated somewhere, and no one determined that. The dialysis unit would not be transferred to Queen Street, although we are not talking about an inpatient program there.

In addition to the ministry's estimate of beds at Queen Street, they have recently come up with another 100 beds at Hamilton Psychiatric Hospital. While this is another new angle on the transfer scheme, we would like to point out that, according to Mr. Morin, the hospital's administrator, from whom you have heard testimony, making those beds available would involve scrapping the plans that were developed in his 1978-79 operational plan. I believe some members of the committee may have that particular document of March 1979; I think we gave copies out. On page five of that document it is interesting to note, and I would like to read it into Hansard—

**Mr. Lawlor:** If I may interject: Throughout the three weeks of these hearings so far that issue has been kept very quiet. The ministry has not made any particular reference throughout that period to the Hamilton situation. My feeling is they are not pressing that issue. Not that they have particularly abandoned it, but it is no longer of any significance in this hearing. But go ahead.

**Mr. De Matteo:** What I'd like to do is point out what the ministry proposes to do. Let's take a look at what Mr. Morin's plans were for those unallocated beds. I am referring to this document from Mr. Morin to all department heads and program directors, dated March 7, 1979, and specifically to page five:

"At the present time the following areas are unallocated: Sentry Manor with 30 beds, Ward D-2 with 20 beds, C-2 with 48 beds. It is our intention to utilize Sentry Manor to develop a forensic program that will have not only the assessment and evaluation part, but also the treatment component for inpatient and outpatient facilities. It is our intention to utilize the C Ward to relocate a series of services that are presently dispersed in buildings located on grounds that should be demolished." I think you ought to underline that, because it's rather strange that this is going to happen. In other words, what you're going to have to do here is keep those programs in those buildings which, in Mr. Morin's opinion, should be demolished. These services are homes for special care, chaplaincy, psychology and a vocational recreation officer.



"The 20 beds unallocated on D-2 will be eventually used to develop a special program for evaluation of some categories of schizophrenic patients." I believe Mr. Morin has plans for probably some worthy programs; however, he finds himself in the position, as I think he stated to this committee, that he is going to have to scrap each one of them to pull off the transfer.

It is our position that the ministry cannot find the space it needs to transfer patients. We must point out that making these beds available at both Queen Street and Hamilton will interrupt current therapeutic programs and interfere with programs planned for the future.

Should Queen Street increase its bed capacity according to the ministry's intention, there is no doubt in our mind that this will simply amount to warehousing patients. As Queen Street takes over the additional responsibilities for admissions from the Lakeshore catchment area, we hold that Queen Street will not be able to meet the mental health needs of both catchment areas in the present and especially in the future. During 1978, Queen Street had an annual admission of 2,242, and Lakeshore an annual admission of 2,549. As Queen Street takes the responsibility for Lakeshore's admission, it will likely have approximately 4,700 yearly admissions.

Moreover, projected population growth in the Lakeshore catchment area will bring enormous pressure to bear on Queen Street in the future. According to the McKinsey report, after examining population growth—and keep in mind that they weren't simply looking at population growth; they were also looking at other things to get an idea of what the demand for psychiatric facilities might be—after examining population growth, together with changes in the age/sex mix, trends in hospital usage and the attrition of chronic patients through death, the increase in demand for beds and admissions will increase by 17 per cent at Queen Street and 37 per cent for Lakeshore. Accordingly, there will be exceptional pressure on Queen Street to discharge patients earlier as it becomes more difficult to meet these growing demands.

In response to these warnings, the Minister of Health assures us that there really isn't a problem. According to the minister, inpatient populations are already declining, despite population growth, and there has been a new shift to outpatient treatment. Since this has been the major thrust of the minister's justification for closing Lakeshore, we should like to take issue with this proposition in depth. While the minister is correct in noting that

there has been a decline in inpatient population at our psychiatric hospitals in the last 10 years—from about 7,800 to 4,000—those statistics are for the most part illusory. Although the annual census of inpatients was decreasing, admissions to Ontario psychiatric hospitals have remained stable and in some instances have increased.

For example, in the 10-year period to which the ministry referred, both Queen Street and Lakeshore have experienced increased admissions. Queen Street had a 62 per cent increase in admissions between 1965 and 1970. That levelled off and remained at that high point from 1970 to 1978. Lakeshore, on the other hand, had a more even rise throughout the 10-year period which amounted to a dramatic 87 per cent increase in admissions. Lakeshore admissions further increased from 2,305 in 1976 to 2,549 in 1978.

[4:15]

By the way, it's really interesting that, in terms of the growth in admissions in these particular hospitals, or the stability you see in some, that according to the McKinsey report they have been meeting these particular demands with a bare minimum of beds in the greater Toronto area.

It's kind of interesting. I heard one of the witnesses—Dr. Wasylenki again—talking about community-based care; I believe he used the example of Saskatchewan which has gone into this particular modality of treatment in a big way. However, it struck me as funny that he pointed out that Saskatchewan has a bed-to-population ratio of something like 0.7 beds per 100,000 population. That's interesting. Ontario has 0.65 beds per 100,000 population. Toronto has 0.41 beds per 100,000 population. What's interesting, too, is that if you look at California—and California kind of led the way in terms of hospital closings—California has 0.75 beds per 100,000 population. One of the things we don't have—and I think it will be becoming obvious in a little while as I speak further—is that we don't even have the community-based care system in place, and yet we're working with a bare minimum of beds. I believe the doctor pointed out that, as far as he was concerned, for a community-based program to work properly there should be, at a bare minimum, at least 0.5 beds per 100,000 population.

Needless to say, these trends that I have been talking about—increased admissions—reflect the philosophy of short-term hospitalization coupled with a drive to empty the hospitals. Importantly, however, a growing proportion of admissions were readmissions. For example, available data on Queen Street



Mental Health Centre indicate that from April 1, 1977, to March 31, 1978, readmissions accounted for 64.6 per cent of all admissions, up from 61.5 per cent in 1975. Available data from Lakeshore indicate that Lakeshore had a readmission rate of approximately 61 per cent for 1978. The statistics reflect a number of inter-related aspects which I'd like to talk about.

First, I think they reflect that a large proportion of the patients receiving treatment at both psychiatric hospitals form a hard core of chronically ill people. These people make up the revolving door. This would seem to be supported by McKinsey's study data which indicated that the psychiatric hospitals treat a greater proportion of people suffering from psychotic and more serious mind-psychotic disorders. These people suffer from disorders that are much less responsive to treatment.

Second, this may also reflect that too many may have been released too soon. These seriously impaired people have obviously not been through it by the new shift in treatment that the minister alluded to in his remarks before this committee. This ad hoc approach has been aptly described as Band-Aid treatment.

Finally, these statistics must surely reflect a lack of a fully effective community-based support system. For the most part, our perception based on reports and observations is that a large proportion of those discharged are living alone in substandard housing without family or community support. Tending to locate close to the institutions, these patients form psychiatric ghettos in the Parkdale and Lakeshore area, mainly in Parkdale.

This weekend I got a little bit of an eye-opener myself. I visited a number of these boarding homes which house psychiatric patients. It would be instructive for the committee, not only to look at the present facilities at Lakeshore, but also look at the kind of facilities that make up the minister's community-based care system. I refer to the group homes on Beaty Avenue in Parkdale, the group homes on Dowling Avenue and the group homes on Madison Avenue. I looked at them and had conversations with some of the patients there. They are dingy, dirty and, while I am no fire inspector, I am sure they are fire traps also.

If you took a look at the kind of existence these people have been relegated to, I think it would be quite an eye-opener. Those homes are not what would meet your standards of a middle-class, shiny kitchen-sink style of living. The reports on a number of these homes on Madison Avenue, as a matter

of fact—and our hospital people do know this—indicate that even the basic necessities of life for these people are not being provided adequately or appropriately. We are just talking about keeping them alive, keeping them fed, clothed and clean—basic hygiene. The other thing that's missing, however, is therapy. There is no therapy at all in these particular group homes or boarding houses.

I think it would be instructive for the committee to look at those and have an investigation into those particular houses that exist on those streets I have named. If you want the addresses, I will surely give them to you.

Generally speaking, these statistics may indicate that the drive to empty the hospital beds may have gone as far as it can go. We say this with respect to (a) the particular type of patient that is now predominantly treated at the psychiatric hospital and (b) the lack of adequate community facilities—and I am going to emphasize this—whose programs are integrated and co-ordinated with the psychiatric hospitals. That's an important thing; the need for programs to be integrated and co-ordinated is something you have heard on and on throughout these committee hearings.

Today's newspapers tell us of alleged abuses of former mental patients in privately run boarding homes. These articles speak of a lack of physical hygiene, poor food and general ill treatment of this hapless group of dependent people. According to the studies done by Community Resources Consultants, approximately 500 beds are available in recognized boarding homes and homes with special care within Metro. This poses serious problems if Queen Street absorbs Lakeshore's annual admission rate of approximately 2,500. Queen Street would then have an annual discharge rate of approximately 4,500, and a majority of these unemployed patients would flock to inexpensive accommodation such as rooming houses and bachelorettes in the area adjacent to the hospital where they are receiving outpatient treatment.

While it is true that existing supervised homes for a small percentage of Lakeshore's outpatients are located in the Parkdale area, the vast majority of Lakeshore's outpatients live in Peel and Etobicoke. We believe that it would be instructive for the committee to review the experience in the United States with respect to the consequences of similar programs aimed at phasing out that country's state psychiatric hospital services. That the phasing-out of state hospital services has led

to a crisis situation for the mentally ill is well documented in numerous official investigations of this situation in that country.

We would refer the committee to the United States Senate report entitled *Nursing Home Care in the United States: Failure in Public Policy* and to the California Senate select committee report on the proposed phase-out of state hospital services in California. We would recommend also that the committee look at the report commissioned by the American Federation of State, County and Municipal Employees entitled *Out of their Beds and into the Streets*. We have provided, I believe, copies of that particular article and an excellent analysis of this process, found in a 1978 issue of *Scientific American*, entitled *Deinstitutionalization and Mental Health Services*, by Ellen Bassuk and Samuel Gerson. This is the California Senate select committee report on the hospital phase-out. It's the property of OPSEU. I lent it to the committee, and perhaps they will return it. I think it would be instructive for them to look at it.

According to these reports, the drive to reduce the inpatient population of mental hospitals has been offset by a huge increase in the rate of admissions and readmissions to those hospitals and in the number of discharged but severely and chronically disturbed former patients who have been consigned to bleak lives in nursing homes, single-room occupancy hotels and skid road rooming houses without proper care and therapy. That's well documented.

With respect to the community health centres, which are supposed to pick up where the hospitals left off, report after report indicates that they have not fulfilled their intended function on behalf of patients returned to the community. There are some obvious reasons: Many of the comprehensive community facilities contemplated in the early 1960s just never materialized. Those centres that do exist are short of funds and are finding that the goal of low-cost care is proving illusory.

Second, centres were developed and administered without connection with the state hospital system; the two systems are almost completely unintegrated and not even in communication with each other so that discharges are inadequately co-ordinated with community facilities. In addition, in the rush to reduce their inpatient populations, the hospitals discharged patients long before community centres had been established and before supporting programs had been developed.

Instead of community centres developing out of a consistent plan based on data collected by systematic research—and I am not talking about research which simply talks about usage; I am talking about research which talks about needs out in the community and the needs of patients—it was assumed that each centre would be shaped by the particular needs of its area as they were perceived by the community itself.

Is Ontario being led down the same path of destruction that occurred in the United States? Apparently the answer is yes. The evidence is abundantly clear. With the proposed closure of Lakeshore hospital, Ontario will have experienced four hospital closings in a period of four years. At the same time that the patient census has declined by approximately 50 per cent, admissions and readmissions have grown dramatically. Time and time again, we see released patients surviving on the fringes of the community, returning to the hospitals for another short stay, only to be released again to an isolated life. Then, having again become despondent, disorganized or violent, they are brought back once more in worse shape. This forms a vicious cycle which has been referred to as the "revolving door" process.

**Mr. Chairman:** Excuse the interruption, Mr. De Matteo. Is that a five-minute bell? We do have these things occur around here once in a while.

**Mr. De Matteo:** Right.

It is equally clear in the Lakeshore closure decision that the new mode of treatment, or what is frequently referred to as deinstitutionalization, is simply being used by the Minister of Health as a method of short-run cost cutting. This decision is marked by an absence of planning and systematic research. You have heard that throughout these hearings. In its stead we have a process of muddling through a bad decision.

OPSEU is not opposed—and we want to be emphatic about this—OPSEU is not opposed to the development of a well-planned community health-care program; nor are we suggesting that large numbers of patients be reinstitutionalized. What we are calling for, however, is an integrated, balanced and co-ordinated mental health-care network that is based on systematic planning and research. We oppose the closing of Lakeshore Psychiatric Hospital because the available data base indicates that it is an indispensable component in the mental health-care system in the area that it now serves. The creation of a community-based network does not presuppose the absence of hospital-based facilities.



In fact, the American experience would indicate otherwise.

Finally, we see no evidence at all that the minister's alternative is based on sound planning and research. Instead of being based on data collected by systematic research, we have an ad hoc process.

**Mr. O'Flynn:** Mr. Chairman, I would like to introduce Sam Wood, the Chief Steward of the Lakeshore local. Would you like him to continue now or to wait until you return?

**Mr. Chairman:** I think we will continue, Mr. O'Flynn, if you don't mind.

**Mr. Wood:** I will try to keep this presentation brief. Most of the information has been provided already by other witnesses who have appeared.

The public picture painted by the Minister of Health when the closure of the hospital was announced was that of an 89-year-old structure which had been neglected and allowed to deteriorate for the entire period. The hospital was described as a fire trap. Of course, this is a false image projected by the ministry stringing together a series of myths, the myths being that Lakeshore is substandard and a fire trap.

[4:30]

First of all, you heard from Trueman Suttis, the maintenance supervisor at the hospital, that the structure has not been neglected or allowed to deteriorate. His figures show that \$1.8 million has been spent on renovations in the past five years. He described an operation in which hospital maintenance staff fixed up small problems as they occurred and accomplished renovation work that was within their capabilities as spare time allowed. He described a system worked out with the Ministry of Government Services through which smaller renovations could be achieved on a non-contract basis. He told the committee of the annual routine of putting in formal requests to MGS for the more major renovation requirements.

In fact, he described a smoothly operating process whereby an old structure was maintained as a useful asset for the taxpayers of Ontario. Mr. Suttis stated, and we agree, that the older buildings at Lakeshore should be replaced eventually. He estimated, however, that with normal maintenance they could continue to serve for at least another 10 years.

Ernie Barnes, the hospital fire safety officer, described a healthy relationship between the hospital and the fire department. From his testimony it was obvious that there had been constant vigilance and constant updating of fire safety at the hospital, to the point that

Mr. Barnes was able to state that Lakeshore Psychiatric Hospital is safer today than it was a decade ago.

As for the fatal fire which supposedly sparked this fire hazard myth, the fire marshal's report lists the cause as arson. We know that the fire was started by a patient with a history of pyromania who was left on an open ward which was totally unsupervised because of lack of staff. This union has long criticized staff cutbacks in institutions. We have expressed concern before other legislative committees that the staff cuts represented a hazard to staff and patients alike.

It is obvious to us that Mr. Timbrell was faced with no emergency situation. There was no need either to rebuild Lakeshore immediately or to abandon it.

Because of the serviceable nature of the present structure at Lakeshore, the ministry can rebuild the hospital a little bit at a time, around the core of the new trades building, which is a mere five years old. In this way, the ministry not only avoids heavy demands on its capital funds, but it also has the chance to see for itself if the projections for bed space demand, outlined in the McKinsey report, are accurate, before committing that capital.

We have prepared a slide show of our own. It is not intended to compare Lakeshore with Queen Street. We agree that the Queen Street hospital is bright and new and modern. It is simply meant to show that Lakeshore is too serviceable a structure to be abandoned. Also highlighted in our presentation is a unique asset of our hospital, the grounds. These are spacious and beautiful. They provide a tranquil atmosphere in which peaceful relaxation is possible, as well as providing a source of recreation.

Lakeshore Psychiatric Hospital is located near the western boundary of Metro Toronto and has been an integral part of the Lakeshore community for the past 85 years.

Lakeshore's new trades complex, built in 1973, is a modern facility which houses the industrial workshop, staff cafeteria, kitchens and maintenance departments. Modern engineering, combined with extensive renovations, make the trades complex a valuable and productive building which is in excellent shape.

The latest kitchen facilities and a spacious cafeteria offer a pleasant and relaxing atmosphere for both staff and patients.

The 89-year-old buildings which comprise the rest of the hospital have been modified over the years to meet improved safety guidelines, and all buildings are fully equipped with strategically located fire escapes; new roofing and improvements in appearance



are additional evidence of the \$1.8 million spent in renovations in the past few years.

But the true value of Lakeshore is in its programs and approaches; vocational and therapeutic counselling; clean, bright communal wards; an innovative industrial therapy program; teamwork and expertise; modern techniques of performance evaluation; and community industrial involvement are all tangibles that must be considered when examining Lakeshore.

This view of the Moorehouse, the drop-in centre built by our volunteer association, is an excellent example of community support at Lakeshore.

The grounds are spacious and picturesque, a successful integration of old and new. The natural beauty of the landscape and the excellent outdoor facilities are immeasurable as adjuncts to therapy.

In view of the contrasting opinions expressed by the ministry, the staff of Lakeshore cordially invite committee members to come out and enjoy a tour of our unique facility.

**Mr. Chairman:** Thank you, gentlemen.

**Mr. Duksza:** I wonder which hospital the minister visited and took pictures of.

**Mr. Chairman:** Questions?

**An hon. member:** The place in Tennessee.

**Mr. O'Flynn:** Would you like me to complete the presentations, Mr. Chairman?

**Mr. Chairman:** Oh, yes; I am sorry.

**Mr. O'Flynn:** I'd like to call on sister Phyllis Paksi, who is the president of the Lakeshore local, to make a presentation to you.

**Ms. Paksi:** Mr. Chairman and members of the committee, on behalf of the staff of Lakeshore, concerned citizens of Metro and Peel, and a vast network of community agencies, we submit these petitions to you, containing more than 30,000 signatures.

We urge you to consider the massive support for the retention of Lakeshore as evidenced by these petitions and supportive testimony that you have heard from the concerned professionals during this legislative hearing.

**Mr. O'Flynn:** In conclusion, Mr. Chairman, in view of the evidence presented before this committee, and in view of the motions of support passed by Metro executive, city of Toronto council, Mississauga council and Etobicoke council, the union recommends the following:

That, due to the functional nature of the present structure at Lakeshore, the ministry rebuild the hospital—a little at a time—

around the core of the new trades building, which is a mere five years old. In this way, the ministry not only avoids heavy demands on its capital funds, but also has the chance to see for itself whether the projections for bed space demand, outlined in the McKinsey report, are accurate, before committing a large sum of money.

**Mr. Chairman:** Thank you. Mr. Conway?

**Mr. Conway:** Mr. O'Flynn and the members of OPSEU, I would like to thank not only you for this extensive and colourful presentation, but also many of your staff who have patiently sat through the many days and hours of sometimes tedious questioning, if not answering.

I want to deal with one or two items that were not discussed at great length, in some cases not at all, in your briefs. I am sure that, as the union leadership, you will have some strong views in this connection.

The minister indicated to members of this committee, when he appeared some days ago and when he made a statement on January 22 announcing the closing of Lakeshore and the planned rationalization, a strong commitment that every effort would be made to relocate staff, both professional and support, throughout the existing system. We were led to believe by people such as Mr. Barnes and Mr. Suttis that very little effort had been made to relocate them, in their own view and perception. Can you, as union president, or any of your colleagues give a more complete picture of what the pattern of relocation appears to be at this time, three or four months after the initial closure, and would you agree with the statement that there seems to be far greater success in the relocation of professional staff than appears to be the case with long-term, long-standing support people like Mr. Suttis and Mr. Barnes?

**Mr. O'Flynn:** I'll ask Sam Wood, who is sitting on such a committee, to respond to that question.

**Mr. Wood:** We placed approximately 60 bargaining unit members, and Ms. Paksi informs me that the payroll at Lakeshore, as of today, is down by slightly more than 100, to 533. That includes union and management. Approximately 100 people have been placed.

**Mr. Conway:** Can you indicate, Mr. Wood, what is the breakdown of that 100 placement factor? Would it be fair to say that a substantial majority of that 100 is professional and that there is a substantial lag in relocating support people?

**Mr. Wood:** Most of the professionals were transferred to Queen Street. Most of the laid-off people were in the clerical field, the kitchen help and housekeepers. The majority of the people placed have been from support services.

**Mr. Conway:** Mr. De Matteo, in the text of your presentation, you stated, on page 12, I believe, that whereas the ministry would indicate a net bed capacity of 217 additional to what was there before the closing of Lakeshore, you would argue that that figure is about twice what your facts would indicate.

What would you suggest, in the event the committee accepted your recommendation, be done with what appears to be substantial capacity there? Do you have any comments in that connection?

If we were to rebuild Lakeshore in the way of your recommendation, am I to believe that during the course of that rebuilding we would then rely on Queen Street to provide the backup inpatient capacity? Could you generally elaborate how you see the intermediate use of that excess bed capacity which, it seems to be generally agreed, is available at Queen Street?

**Mr. De Matteo:** It would seem to me entirely possible that you could basically do that. Again, however, keep in mind that we don't have time on our side with respect to how long such a program would take for the rebuilding. If you look at a partial phased-in program, that would not tax the facilities at Queen Street or at Lakeshore.

**Mr. Conway:** It has been suggested by at least one witness of a professional character that the optimal size for a psychiatric facility is in the order of 150 to 300 beds. I think the member for Parkdale would concur in that; if he doesn't I would certainly appreciate his comments.

If we are to be led to believe that that does represent, from the point of view of professional treatment and the factor of economics, the kind of facility that really is optimal—your recommendation calls for the replacement of Lakeshore as it is in a staged way—would you see the capacity of the new Lakeshore of your description being in the order of 150 to 300 beds?

**Mr. De Matteo:** That would be very difficult for me to answer. For one thing, I am not a clinician. However, I would say that any kind of estimation of this kind of thing should be based on a very close review of the available information on what the needs are in that particular community and all those communities that would be

affected. It shouldn't be based, as I mentioned before, simply on usage analysis of the facilities. We should look at what is currently needed in the community in terms of psychiatric care.

I believe Janet Howard made some very interesting observations yesterday about the extent of needs in the communities she is familiar with, that they are continually growing and mushrooming. I can't really give you an idea of the causation of these kinds of things, but what we do see is a growth in those kinds of needs. I couldn't give you a hard answer and say that it should be a 150-bed facility. I think, when you are going to make those kinds of estimates, that they should be based on sound data. What you are suggesting would seem reasonable anyway.

**Mr. Conway:** I guess my point is simply that you have agreed that there appear to be in the order of 100 to 120 excess beds possible at the Queen Street mental health facility.

**Mr. De Matteo:** Clinically.

**Mr. Conway:** Clinically. I assume that figure is so, at a time when the trend to deinstitutionalize, as we have been told by a great number of witnesses, is proceeding apace. The degree to which that occurs, of course, is an arguable point. What I am concerned about is wanting seriously to review your recommendation to rebuild Lakeshore. I am mindful of the 120 beds that are in place at Queen Street, a facility which I think it now generally regarded as being overbuilt.

If, indeed, that is the case, to service the inpatient needs of the Metropolitan Toronto area, would we be looking at a facility, theoretically speaking, of perhaps less than 150 beds at Lakeshore? I am interested in your comments in that connection, as to how we tie the proposal to rebuild the Lakeshore facility to what is known and generally agreed to as excess capacity at Queen Street.

**Mr. O'Flynn:** I would suggest that if our recommendation is accepted the indecent haste to shuffle patients around and squeeze them into Queen Street will cease. Then there would be time for slow and thorough investigation into the needs of the area and into the rebuilding and the extent to which it should be rebuilt in Lakeshore.

[4:45]

**Mr. Conway:** As you, Mr. O'Flynn, are perhaps more cognizant than most people in this room and elsewhere that in this day and age of declining resources in terms of



government funding of social services and other things, you have no difficulty in recognizing that within the limited financial ability of this and other governments this would be none the less a very good priority expenditure, in terms of spending X millions of dollars over years to rebuild Lakeshore?

**Mr. O'Flynn:** I think you have got to understand that the union doesn't fight every closure. As I said at the beginning, the union has a social responsibility that it recognizes, apart from its responsibility to protect the interests of its members.

You may be aware of recent announcements regarding closure of an institution in Kawartha and one in Pine Ridge. The union has adopted the sensible approach that there isn't a good case that can be made for keeping those open, and so is pushing all of its efforts into trying to find jobs for those people.

In this case, the people who work there are of the opinion that they are providing a very important service to the community, and one that the community will be the poorer for if this place closes down. I would like you to take that as the context in which we make the presentation.

**Mr. Conway:** I want to conclude by saying as one of the members of the select committee on health care costs and financing that you and your union proved the reasonableness of your case on that occasion. I really do appreciate the presentation you have made. It does fly in the face of some other evidence, but that is not surprising—in some respects; not all, certainly. I do appreciate your presentation.

**Mr. De Matteo:** To add to what Sean said, I think when we are talking about developing that kind of inpatient facility at Lakeshore, coupled with what we were talking about before, deinstitutionalization, I think the emphasis should be on a program or plan which co-ordinates those activities, outpatient or community-based activities, with what is going on in the hospital-based facility itself.

I was disturbed yesterday by the testimony that was given by two people, Ms. McLaughlin and Dr. Olsen, pointing out that the planning process going on in the outpatient committee headed by Dr. Lynes seems to be very disorganized, or has an aspect of chaos about it, in terms of who is going to get what and who is going to co-ordinate what.

One of the statements made by Dr. Olsen, I believe, and corroborated by Ms. McLaughlin, was that in these kinds of processes when you begin to give communities money

for facilities they want to go off on their own and provide that particular facility independent of the hospitals. What we have to look at is the US experience, or the BC experience that was referred to in yesterday's testimony, which pointed out that it will doom those programs to failure when you set up community-based programs that are unco-ordinated and simply based on what that community perceives its needs to be.

I might just add, in terms of the 150-bed facility, that Sam has just mentioned to me that, for instance, the Peel and Etobicoke parts of the Lakeshore catchment area will fill the beds allocated at Lakeshore at present to 85 per cent capacity.

**Mr. Wood:** Can I just comment on that last part, to give a little background? Peel and Etobicoke patients have not been transferred from Lakeshore. When they are, it is approximately 60 patients, which will bring Queen Street well over 85 per cent capacity. In the meantime, there are a number of inpatient programs left at Lakeshore—the alcoholic unit, ward B, ward A, which is the long-term, the SOC unit—and we have no word on what is going to happen to these programs.

Along with other existing outpatient programs that aren't going to Queen Street, I would estimate there are 10 programs at Lakeshore that aren't slated for Queen Street and we don't know where the ministry plans to put them.

**Mr. Chairman:** The committee is going to have to recess now to vote. We will be back right after we vote, which will be no more than 10 minutes.

The committee recessed at 4:49 p.m. and resumed at 5:05 p.m.

On resumption:

**Mr. Chairman:** We are running a little short on time now, and Mr. Ramsay, Mr. Johnston and Mr. Lawlor have indicated they have questions. We have another delegation at 5:30; so perhaps we could start, even though we don't have the full membership of the committee back yet. Mr. Ramsay?

**Mr. Ramsay:** A couple of points of clarification first, if I might. I noticed today in your submission—which, incidentally, I felt was excellent, and I congratulate you on it—you mentioned a figure of \$1.8 million spent on renovations. In the submission you had made earlier, which I have read, you mentioned a figure of \$2.5 million.

**Mr. Wood:** The \$1.8 million is strictly the cost to the Ministry of Government Services. The \$2.5 million included the cost of pur-



chasing items and other incidentals at Lakeshore. The figure of \$1.8 million we used because it was given by Mr. Suttis. That's the cost of MGS.

**Mr. Ramsay:** One other point of clarification: I believe it was Mr. O'Flynn who referred to the co-operation of the union in other hospital closings.

**Mr. O'Flynn:** No, I didn't say hospital closings. I said other institutional closings.

**Mr. Ramsay:** That's what I wanted to get a little more clarification on, if I might.

**Mr. O'Flynn:** Kawartha is a ComSoc facility, as is Pine Ridge. These are two ComSoc training facilities which have been given the axe in the last couple of weeks by the minister. We have not opposed those closings because the facts don't allow us to. There's a very clear case for closing those two training centres.

**Mr. Ramsay:** I see.

**Mr. O'Flynn:** I was making the point that we are not mindlessly opposing closures.

**Mr. Ramsay:** In that same respect then, has there been an ongoing dialogue between the ministry and your union since this whole matter surfaced in January? Did you have a chance for any input with the ministry when this came about in January, when the announcement was made?

**Mr. O'Flynn:** No.

**Mr. Ramsay:** What about ministry assistance in locating jobs for those who might be displaced?

**Mr. O'Flynn:** That's a different matter, of course. We have an ongoing relationship with commission staff and ministry staff. Very clearly there are problems there, and we are striving with these ministry officials and commission officials to overcome those kind of problems. Shall we say that the heat of the debate over the closure has accelerated the amount of co-operation we have got?

**Mr. Ramsay:** Is it too early to make an estimate of the number of persons who perhaps will be left without employment; who will have to look to other areas or other fields?

**Mr. O'Flynn:** Yes, it is too early. I would estimate at the moment that the figures are around 130 or 140.

**Mr. Ramsay:** I think Mr. Wood referred to the difference between the payroll of a month or so ago and today's as being about 100 fewer people; is that correct?

**Mr. Wood:** That also includes the people who have been transferred to Queen Street.

**Mr. Ramsay:** I see.

**Mr. Wood:** The type of people who are laid off are the type of workers who need a facility to have a job; they are housekeepers, kitchen help, clerical people.

**Mr. Blundy:** How many would be in that category of the 100 you spoke of?

**Mr. Wood:** Out of 130, I would say 100 fall into those three categories.

**Mr. O'Flynn:** But that has not been the basis of our presentation. The basis of our presentation has been that this is a facility that is needed in the community.

**Mr. Ramsay:** I appreciate that, sir, but I think it is a matter of concern to the members of the committee that there are people who are being uprooted and will have to look for different employment, perhaps unsatisfactory employment. I think it is a matter of concern, and I am not suggesting that it is the only concern of your organization. In fact, it leads to my final question.

You have expressed several concerns today in what I listened to and what I read in the brief before. What would you say is the greatest objection to the closing of Lakeshore?

**Mr. O'Flynn:** In summary, it is this: I was here last Thursday waiting to make a presentation to this committee. I listened to a doctor—and I can't recall his name now; he was an administrator. He said that in his experience, and with his background of knowledge, it would take five years to plan the transfer of the hospital services into the community—five years of planning.

The main point of our presentation is that this kind of planning has not taken place. It is impossible to make the switch as has been done by the ministry. You can't decide to close it and then look around and see how you are going to provide those facilities if any estimate of five years to prepare those facilities and services, and to put them into action, is accurate.

**Mr. Ramsay:** Mr. Chairman, I said that was my last question, but I have noted something I have written down here. May I continue?

**Mr. Chairman:** Of course.

**Mr. Ramsay:** This had to do with our comments earlier relative to the basement not being suitable for day-care services, Mr. De Matteo—

**Mr. O'Flynn:** No. That was George Sneyd, who works at the facility; he made that point.

**Mr. Ramsay:** Yes. I toured those facilities the other day and, just speaking as a layman on a personal basis, I didn't think they were unsatisfactory. I was wondering how they

would compare with similar facilities at Lakeshore. Would they not be an improvement over Lakeshore?

**Mr. O'Flynn:** I will let one of the experts speak to that.

**Mr. Wood:** Perhaps I can answer that for you. At Lakeshore we have a number of small buildings that are separate from the rest of the hospital: the lake house, the gate house, the school house. These are small buildings that are much like homes and they tend to be used for therapy programs. While they are not as new as Queen Street, the settings are more than adequate and actually quite picturesque, as I am sure you will see on Thursday.

**Mr. Ramsay:** I have been to Lakeshore, Mr. Wood—I have been to both Lakeshore and to Queen Street—and I won't be going back on Thursday. I wanted to see these places early in the committee hearings.

**Mr. Wood:** That is unfortunate. We would have liked you to have seen it from our point of view.

**Mr. Ramsay:** Fine. Thank you.

[5:15]

**Mr. Sneyd:** If I may make a short response as well, I work at Queen Street. At the present time we have four satellite centres in the community. One is out near Danforth and Woodbine; one is on Ontario Street; one is in the west end on Queen Street, approximately close to Roncesvalles; and one is in the north end of the city at Glencairn and Bathurst.

Three of those facilities are in what the staff and I, as well as the administration, I think, feel are very adequately serviced areas.

The fourth program, called the Dundas Day Care Psychiatric Services, is at present located in Central Neighbourhood House. They were looking for other space and, because of the expense and the area of the city in which they are located, the only available space they could get at that time was the basement of something called the O'Neill Public Baths, which is located just south of Seaton House on George Street. They were perforce reluctant but it was a larger physical area and we are going to accept that. The Ministry of Government Services offered to look for other places and they immediately jumped at the chance because a basement is a basement.

I appreciate the fact that you have been to Queen Street and have been in basement areas there, but the areas that are used are fragmented; there are corridors with rooms off the corridors. For example, the Northern

Service treatment team that is currently housed on the first floor feels that it isn't conducive to the kinds of activities and the kind of flow, with staff being present and available in each of the areas, that you are going to have rooms that are cut off one from the other. You have a minimal staff in a day-care program, approximately six or seven nursing staff and one or two non-nursing clinical people, and you can't really keep track of what is going on in the different rooms, separated as they are, and scattered through a basement area. That is their feeling.

**Mr. Ramsay:** I wouldn't want to argue with a professional person on that point. I am just speaking again as a layman. Those facilities that are described as basement facilities at Queen Street seem to me to be somewhat nicer than what you would think of when you think of a basement; they seem relatively adequate. But, as I say, professional people think differently in that respect.

**Mr. Lawlor:** Before asking a question or two—and I will keep them short—I think the members of this committee owe you an enormous debt, and I think they should say so. The research that has gone into this and the presentation is quite elaborate. It has been a superb job from the beginning.

The original brief which was circulated to all members was expansive, searching and gave us the background and basis of fact upon which we could operate here. It is that kind of thing we are most grateful for. I don't want to be too invidious, but such facts and statistics were not forthcoming from the ministry; at least I haven't seen any documentation in that particular regard. In other words, the whole weight has fallen upon your shoulders. You have borne it extremely well, and I want to congratulate you.

The weight of today's brief has been on the present as to the capacity of Queen Street to withstand this inundation. I would like you to address yourself, if you will, if you feel in a position to do so, with respect to the future.

Have you any statistics of your own, or in your analysis arising out of the McKinsey report, as to what the capacity for Queen Street would be in 1987, which is the year set by McKinsey?

**Mr. De Matteo:** In fact, one of our major arguments in the first brief that we put together—and it is not really absent from the presentation we gave today—was that, after looking at the sources for the McKinsey projections those projections are accurate. They have not simply made projections based



on population growth itself, but they have looked at the demographic mix, so to speak. They have also taken into consideration hospital usage. They have also taken into consideration the attrition of chronic patients through death. It seems to me that the estimations they come up with—a 37 per cent increase by 1987 for Lakeshore and 17 per cent for Queen Street—are quite accurate.

However, when you look at the possibility of Queen Street picking up that combined catchment area of a growth of 17 per cent in its own area and 37 per cent in an adjacent area, it is quite frightening. We made some initial calculations based on the data that had been made available to us by the ministry; and keep in mind that at the time we were given this information, in late January, there were 296 patients who were going to be transferred to Queen Street. Again, that game plan has been altered, and I would suspect it has been altered because of the kinds of information we were able to make public. When I say altered, I mean that a number of programs the minister has mentioned are not going to be transferred to the Queen Street catchment area.

None the less, we still think that doesn't change the kinds of demands that are going to be placed on Queen Street, because we are talking about programs and not about switching catchment areas. They are still going to get the same catchment area; and eventually that is going to catch up again.

That is what we are concerned about, those basic population projections. We made some initial projections and, looking at 1987, we saw that Queen Street would exceed its capacity by 325 beds; that is, it would have an excess of 325 beds. Those were original estimates. I haven't reworked those figures.

But let me say something about the new element that the minister has thrown into the arena. He has said—and this was in the fact sheet that he brought out—"We are going to rely on outpatient or community-based treatment." To back that up, he also uses the declining population in the hospitals as a figure. I believe that is not an accurate indication of what a hospital does, simply by its inpatient population. What is more relevant are the admission figures.

What we are basically saying is this: Consideration must be given to both the projected increase in population and the fact that there seems to be overwhelming evidence to suggest that the kinds of patients the hospitals are treating are chronically ill. The latter point is reflected in two basic facts. McKinsey, in presenting to us the

facts as to who uses the hospitals, finds that it tends to be those suffering from more severe psychiatric ailments. In addition, the readmission rates are a good reflection of the kind of chronically ill patient who is released early, only to break down very soon and be back in the hospital again.

These are the kinds of things that give us an indication that, should this decision go through *holus-bolus*, we will have a crisis on our hands with respect to the provision of mental health services for those combined catchment areas.

**Mr. Lawlor:** Coming back to the present, if you took the McKinsey catchment area, and the reallocation of part of that area to Queen Street, as against Lakeshore, have you any estimate of the number of beds that would be required as far as Queen Street is concerned?

**Mr. De Matteo:** Yes, we make mention of it in our brief. One of the McKinsey proposals was to transfer a portion of Lakeshore's catchment area to Queen Street as a readjustment in catchment area.

**Mr. Lawlor:** What would that mean in terms of beds?

**Mr. De Matteo:** That would amount to a 20 per cent increase. It would be 20 per cent of Lakeshore's catchment area being shifted over to Queen Street. I believe that North York would be shifted over to the Queen Street catchment area. All you have to do there is look again at the population projections and at what the slated increase would be; I think you would get an idea by adding that 20 per cent increase to what the population would be in the near future. I'm not a mathematical wizard, and I don't have that there. What McKinsey is saying, however, is that should you increase the Queen Street catchment area by 20 per cent, Queen Street would be operating at full capacity by 1987, I believe.

**Mr. Wood:** Can I comment on that to give a little background? Last November, the ministry announced that Lakeshore would lose North York's catchment area; the plans were set, and they were discussing the number of staff to go with the number of patients. Then, after Christmas, the ministry did a complete about-face and, apparently disregarding the McKinsey report, announced they were closing Lakeshore entirely. They started off on the right foot.

**Mr. Lawlor:** Mr. Chairman, I had other questions. My colleagues want to get in on this thing. I just want to make a very brief comment. One of the questions had



to do with the retention. Since these hearings started, as has been mentioned, a number of facilities now are going to be retained on the Lakeshore site. If they're going to retain it to that extent under duress, because they cannot find any alternative accommodation for these bodies—I think that's generally accepted—they will end up at the end of the day with all the rest, in my opinion, of these outpatient facilities too. Therefore, Lakeshore would be a fairly extensive operation. Why not leave the operation as it stands, since what the ministry originally intended cannot be met on their own terms in any event?

**Mr. O'Flynn:** There is a certain aspect in which a lot of these statements are just rumours. It would seem, in my opinion, that they are rumours to take the heat off. But, as far as I know, there is no commitment to do anything concrete.

**Mr. Lawlor:** You're perfectly right.

**Mr. O'Flynn:** Thank you.

**Mr. Chairman:** We have about three minutes left. I have Mr. Johnston and Mr. McClellan on my list.

**Mr. R. F. Johnston:** In view of the fact that we did have to roar upstairs and missed some time, is it possible to extend it for about five minutes or so? I have two questions.

**Mr. McClellan:** I have one question.

**Mr. Chairman:** Is it the committee's wish that we go beyond six?

**Mr. Conway:** I certainly wouldn't in any way wish to make the members of the committee feel as if they were closed.

**Mr. R. F. Johnston:** Exactly. Yes, it would be hard—

**Mr. Chairman:** Perhaps we could extend it for another five minutes. Do you think you could get your questions in in five minutes?

**Mr. McClellan:** I can get mine in in about 30 seconds.

**Mr. R. F. Johnston:** Okay. I agree with Pat; I think your submission is fantastic and shows the value of having hung around for the whole time. You've been able, I think, to pull out a lot of the key aspects of this whole case.

My questions go as follows: One of the things that came up—I think it was in Dr. Fisher's presentation and in a couple of others—was that Queen Street wasn't like other institutions of the potential size, 650-odd beds or whatever. It was decentralized into four different groups, clearly distinct and able to run their own show; it was like

having four little hospitals and, therefore, it was a good program to deal with.

One of the things that I find valuable about your breakdown of beds, and your talking about guesting, is that it's clear to me that some of these people in the buildings that you show, besides the psychogeriatric area, are all placed by area, I think. Is that true?

**Mr. De Matteo:** Yes, at least three of the towers are by area, and the two geriatrics are functional units.

**Mr. R. F. Johnston:** On their own, right? And the Eastern Service, as we understood it, is going to take over Lakeshore catchment; the doctor indicated that he saw some problem with that and that there was a huge gap.

**Mr. Sneyd:** Southeastern Service would take the borough of Etobicoke. There was also that leapfrog aspect, I think, that Dr. Anderson referred to. Southeastern Service now deals with the area from Spadina east to Victoria Park, and Southwestern Service from Spadina west to the Humber River. We would leapfrog over that area and take the borough of Etobicoke as an additional catchment area.

[5:30]

**Mr. R. F. Johnston:** At this point, George, do some of the people that you guest out go into other buildings that are not the mandate of, say, the Southeastern Service?

**Mr. Sneyd:** Oh, quite definitely.

**Mr. R. F. Johnston:** So they just sort of disappear?

**Mr. Sneyd:** This past weekend, on Friday, the treatment team met; we went through the list of patients and tried to decide which six patients who were in our inpatient ward, the 34-bed ward, could best adapt to a changed environment. We came up with six names; all six of those patients were transferred to Southwestern Service to sleep in a completely different building, because we had six patients coming from the crisis unit and we had to make beds available for them.

**Mr. R. F. Johnston:** I guess what I am saying is that by adding more people, and with the breakdown the way it is, that same kind of jurisdictional administrative problem is going to be increased. Would you agree with that?

**Mr. Sneyd:** Yes, I would agree with that.

**Mr. R. F. Johnston:** Okay. Good. Another question is on the use of space—and I'm going to try to speed it up. At the moment, as I understand it, there are two vacant floors

essentially that are not being used, and that's all. The others are being used for one purpose or another.

**Mr. Sneyd:** There's a 34-bed ward on Southeastern Service that is empty now, and there's the 14-bed unit on psychogeriatric service that is empty. There is a 14-bed ward in Northern Service that houses a day-care program.

**Mr. R. F. Johnston:** Right. My question comes out of a question that was raised earlier about usage of those areas. It seems to me that what your report documents is a very good thing; that is, there's a major readmission problem in psychiatric services, and the community support services are not dealing with that or have not been able to deal with that. We have no reason to believe they're going to deal with that. Can you see usages in hospital, connecting with community services, that that space could be used for; so the ministry wouldn't have to worry that there was space just going wanting?

**Mr. De Matteo:** I would like George to comment on that further, but I just want to point out one thing. I attended a luncheon of the Peel Family Services, and what I found interesting was the question of the people in the audience: "Why are all these vacant beds at Queen Street?" I had to remind them that there weren't any vacant beds at Queen Street; there was space that could be allotted for beds. People have the impression that the hospital somehow is being underutilized because beds aren't set up, but the thing to realize is that the programs are set up in its stead, and a psychiatric hospital should not consist solely of beds. That is warehousing. Perhaps George would like to comment further.

**Mr. Sneyd:** It has been a while since I have read the McKinsey report, but it is my belief—and if it is not in the McKinsey report, it is my own then—that Queen Street Mental Health Centre could slightly enlarge its catchment area. It could take East York, Leaside and west North York, or perhaps all of the borough of North York. That would fill the empty beds and leave both Lakeshore and Whitby intact, or at least reduced in size.

**Mr. Chairman:** Mr. McClellan?

**Mr. McClellan:** Thank you. I want to ask the delegation from OPSEU whether you, at Queen Street, have experienced staff cuts over the past couple of years, I guess since 1976 when the screws started to be put on health-care budgets.

**Mr. Sneyd:** We certainly have.

**Mr. McClellan:** Could you tell us how many?

**Mr. Sneyd:** My accuracy is probably lacking. Maybe you should ask Mr. Jappy. I would say there has been a staff reduction of somewhere between 200 and 300.

**Mr. De Matteo:** That is since 1972, isn't it, George? I think we went over those figures.

**Mr. Sneyd:** It is since about 1973.

**Mr. McClellan:** I need to follow this up. Mr. Sneyd talked about the self-care unit; he said that he had worked—

**Mr. Sneyd:** Yes. That is part of the program I worked on, the self-care unit.

**Mr. McClellan:** When the self-care unit was set up, was it set up on the basis of continuous staff supervision?

**Mr. Sneyd:** It was created partly because we did have a reduced inpatient caseload and because we had a large reduction in staff.

We came up with the idea that there are some patients who require further inpatient care and are able to take responsibility for themselves with minimum supervision. What we have done on the fifth floor of Southeastern Service is create this 20-bed self-care unit.

In the hours from eight in the evening until eight in the morning we have hired part-time students—there are two of them on each evening—who are available should there be some sort of upset. If there were a fire, or if a patient is or becomes depressed and wants to talk to someone, the self-care advisers, as we call them, are available for such emergencies.

But this was done largely to cope with cutbacks in staff, and to try to provide extended care for some of the patients who required it.

**Mr. McClellan:** If you had been more adequately staffed, would you have put regular full-time staff on?

**Mr. Sneyd:** Yes, we would have. Definitely.

**Mr. O'Flynn:** The essence of this self-care issue is that if you fill up that space with beds, by definition you destroy the program because there isn't enough space in which it can operate.

**Mr. McClellan:** I understand that argument. My concern was around the fire fatality which occurred. According to the fire safety report, arson was caused by a patient who was in the self-care unit during the period when there was no supervision. I now understand that lack of supervision in the evening period was a consequence of cutbacks in staff at the hospital, contrary to some other versions of the cause of that fatality.

**Mr. De Matteo:** Could I comment on an aspect of the staff cutbacks? One of the



interesting things to note, as George mentioned, is that there have been cutbacks since 1973—perhaps in the range of 200, would you say, George?

**Mr. Sneyd:** I would say at least 200.

**Mr. De Matteo:** When you are talking about that, you are talking about a staff of 800 people at Queen Street. That is complement, which means that the positions may not be filled actually, and I believe that is the case. When I was going over this last fall there were a number of vacant positions as a result of people quitting, just not being there any longer, or being on long-term disability programs. These have not yet been filled either. So you have a shortfall in the complement.

**Mr. Chairman:** I want to underline what Mr. Lawlor and Mr. Johnston have said with respect to your presentation. It was well documented and well researched, and we appreciate your contribution. Thank you very much. Sorry about the time.

**Mr. McClellan:** I'm sorry; I have made a confusion between the fire at Queen Street and the fire at Lakeshore which I need to clear up for the sake of the record.

**Mr. Sneyd:** The fire you are referring to did not occur in the self-care unit at Queen Street.

**Mr. McClellan:** Let me make it clear I was totally confused.

**Mr. De Matteo:** Mr. Chairman, just one thing: I want to table the California Senate select committee report. I think it might be useful for your considerations.

**Mr. Chairman:** Thank you very much, Mr. De Matteo.

We have a group of people who wish to come forward for a few moments. Mr. Beare Weatherup, Zoya Stevenson, Alderman Ruprecht and Alderman Barbara Adams.

I presume you are all talking about the same thing, group homes as it relates to the Parkdale area. I would suggest to you that our terms of reference are the matters related to the Lakeshore Psychiatric Hospital closing; so I would ask you to confine your remarks to that particular closing. If you want to relate it to the group home situation as it pertains to the closing, and the added pressure it will put on the facilities out there, that would be appropriate.

Alderman Ruprecht. I believe you wish to start off, or Mr. Weatherup? It doesn't matter. You can sort that out.

**Mr. Weatherup:** My name is Beare Weatherup, and I'm chairman of the Parkdale Working Group on Bachelorettes. We

asked a group of people in the community to come out today to speak to you about the closing of Lakeshore Psychiatric Hospital and the effect it's going to have on Parkdale particularly. I will start off by introducing the people who are here.

We have Jacki Rankine, who is a representative of the Beaty Avenue residents; Alderman Barbara Adams; Alderman Tony Ruprecht; Zoya Stevenson, who is a community legal worker for Parkdale Legal Services; and Nelly Kuzmich, a resident of Spencer Avenue. If there are any questions after I say a few words, they could be directed at all of us, or if other people have things they want to say, they can say them at that time.

I became involved with the Parkdale Working Group on Bachelorettes, because of my concern about the overcrowding that already exists in Parkdale. We were concerned about the noise, the garbage and the inadequate housing that was already prevalent in the community before we gained any knowledge that there was some suggestion that Lakeshore was being closed.

My family and I live on Cowan Avenue in Parkdale, and we have to live with this problem all the time. My main concern is about the preservation of our community. Parkdale already has an overabundance of singles accommodation, which has acted to the detriment of family accommodation. The mayor's task force on bachelorettes was set up to partially remedy that problem. You heard Janet Howard speaking about that a few days ago.

In the 30-block area of South Parkdale, which we feel is going to take the majority of outpatient people from the Queen Street Mental Health Centre area, we have 36 group homes and nursing homes housing 1,100 people; and that number has probably increased. We have between 15 and 20 expsychiatric homes housing 340 people, and that number is up. We have about 250 illegal bachelorette buildings. That's 3,000 illegal units in South Parkdale alone. On top of that we have numerous boarding and lodging houses, some of which house quasi-group homes run by people who have decided—since the government isn't willing to fund them—to make money off people who cannot afford any better and simply to take advantage of the situation.

We have one of the highest densities of any area in Toronto. We had 90 persons per acre, and now we are up over 100 persons per acre which, compared to most other residential areas, is extremely high. This is on top of the fact that we're basi-



cally a working-class district. We have the highest unemployment rate in Toronto—25 per cent unemployment—and we already have a lot of working poor people who have a lot of problems already, a lot of drinking problems. Unfortunately, Bill McGinnis from Archway Community Mental Health Centre wasn't able to be here; he was going to talk about that. But the problem was already there before people even considered closing Lakeshore.

We've heard from the director of outpatient services of Lakeshore hospital that it now serves 1,700 people and we can anticipate 850 more people on top of the problems we already have. We can't take any more people in South Parkdale with these problems. For those reasons, we ask that it be reconsidered, and if people are talking about, as someone mentioned earlier, five years to blend them into the community, then some time and consideration should be spent in discussing this matter.

[5:45]

**Mr. Chairman:** Alderman Ruprecht, do you wish to make some comments?

**Alderman Ruprecht:** Yes, Mr. Chairman, I called a meeting about two weeks ago on the question of closing Lakeshore Psychiatric Hospital and on the question of group homes in the area. It was very clear, in terms of the attendance at that meeting—we had 120 people there and close to 30 more people who couldn't even get in—what the outcome of the meeting was. Mainly, we have a mandate, and that mandate is unequivocally clear: "No more ex-psychiatric patients, no more group homes, no more 'approved' homes into our area."

The reason is very simple to understand. We have the greatest number of so-called group homes for ex-psychiatric patients who come into our area. We have residential care facilities. We have halfway houses. We have bachelorettes on top of that. The social fibre of the community is already so very weak that, if we now were to have to deal with additional people coming into our area, we just don't know what the effect of that would be.

I'm sure the residents who attended the meeting are adamantly opposed to the closing of Lakeshore Psychiatric and to any more homes for outpatients or ex-psychiatric patients in our area. I did look at the Queen Street facility, and I've been at Lakeshore Psychiatric Hospital. I'm not at all convinced that the Queen Street facility would be able to handle, in terms of programs, the great influx that's coming in from Lakeshore Psychiatric Hospital.

We can also say that the South Parkdale area would not be able to handle the influx of people coming into our area. An amount of \$1.3 million is being allocated for outpatient programs. It is very clear to us where these people will go; they will go where the rents are cheap, and the province will send them into an area that is close and where some money can be saved. That really brings people into the Parkdale area. We simply can't deal with the additional pressures of having more people come in.

What I'd like to do is to read to you what that meeting resolved. "1. That the Parkdale residents adamantly oppose the closing of Lakeshore Psychiatric Hospital.

"2. That the provincial government hold special hearings to determine the effects of the closing of Lakeshore Psychiatric Hospital on the Parkdale area." We felt that was never adequately established, what the Lakeshore closing will mean to the Parkdale area. For that matter, I don't think the effects have been adequately outlined in any area.

"3. That the boroughs lift their restrictive zoning regulations and provide an open-door policy for group homes in their respective areas." That, of course, has direct impact on our problem, inasmuch as Scarborough, Etobicoke, North York and York have restrictive zoning regulations. Obviously, additional pressures are going to be put on to the Parkdale area to house people.

"4. That until an adequate policy for the regulations and standards of group homes, boarding and lodging homes has been established, Parkdale should be declared off limits for any residential care facility." That's how strong the reaction has been.

"5. That the standards of care and supervision of licensed and unlicensed boarding homes catering to psychiatric outpatients be improved." There was also a strong feeling at that meeting that there wasn't enough supervision exercised over those homes which the province handles. Certainly there isn't enough supervision of 'approved' homes, which take in ex-psychiatric patients; and obviously there would be no supervision whatsoever of homes that are operated by private people who have boarding and lodging homes.

"6. That there should be psychiatric outpatient programs established in borough hospitals, and that an adequate number of residential care facilities be located near these institutions." I understand that is being contemplated right now.

In short, Mr. Chairman, it is very clear to Parkdale people that if Lakeshore Psychiatric Hospital closes, the basic and major brunt will

have to be borne by the Parkdale area. What we'd like to do as citizens, and as representatives, is to make sure that one area does not become a ghetto or a major problem area.

**Mr. Chairman:** Thank you very much. Alderman Adams, would you care to add to that?

**Alderman Adams:** I think there are two primary concerns; the first is the care of the patients who are at present being served by Lakeshore Psychiatric Hospital, and the second is certainly the effect on the Parkdale community.

I don't know how many of you are familiar with Parkdale. If you've spent any time there walking around, particularly when the weather is warmer, you see people walking on the streets in a very dazed condition, poorly clothed and looking underfed, malnourished. It's certainly a very distressing sight in a city that prides itself as being People City and a healthy city.

The situation in Parkdale illustrates the problem that has been growing since the province began cutting back on social services and health services in 1975. We need more services, not less. We need much more careful planning.

I think you have my letter of April 20; so I won't repeat all the things contained there. But I think the main point is that, while I support closing down for refurbishing of outdated institutions, you don't do that until you have something better to give to people who are being served by that facility. We have a tremendous problem with unlicensed boarding and lodging homes which are really exploiting psychiatric patients. Many of these landlords have applied to the Queen Street Mental Health Centre for approval to have people referred to them, and I think more than half of those have not been approved by Queen Street. It has only been at the initiative of the staff, who are anxious to get their patients out into a supportive community, that they have been checking into these premises. I think the province has been very lax in the way it has not pushed for better standards in these facilities. I think it should take a much stronger leadership role, working with the city and with Metro, to provide decent services for many of these people. They're out there on the streets right now, and there are going to be many more of them if you close Lakeshore.

**Mr. Chairman:** Is there anyone else in your group who would wish to make a comment?

**Ms. Z. Stevenson:** I'm a community legal worker at Parkdale Legal Services. I'd like to

comment briefly on the kinds of problems that we encounter as a service for low-income people in the Parkdale area. We handle a caseload of close to 1,000 cases. Much of our time is spent dealing with people who have psychiatric problems; they don't really have legal problems, but they have psychiatric problems and they have severe housing problems.

We have trouble finding good housing accommodation for these people. There's no service in the community that helps us to help these people alleviate some of the problems which get them into conflict with the law in different ways. It's very severe. Every agency that services Parkdale, including the Community Information Centre, the Archway mental health centre and the Parkdale Jobs Office, already has to deal with people who have psychiatric problems. The Parkdale Jobs Office, for instance, has a special program for people who are seeking employment but need special counselling because they've just come out of psychiatric hospitals.

Already these agencies along the Queen Street strip have indicated, as we feel, that we're overloaded with this type of client. In the long run it would be costing the province lots more money to be closing down Lakeshore. We are going to be the people having to deal with the overload; that's going to cost money, and it's something we don't think is good planning.

The other point that I'd like to make has to do with the whole situation vis-à-vis planning: It doesn't make a lot of sense to me, given that you are dealing with a low-income community with severe problems as it is. The part II study of the city of Toronto identified that there is a need to increase the availability of family accommodation in the community. They haven't worked out the ways of doing that, but they identified this as a need and said that more family accommodation in Parkdale was necessary to provide the community with some stability.

It doesn't make sense to me to be closing down a hospital and putting pressure on a community when, at the same time, another level of government is saying family accommodation is a need. What this action will do is destroy any hopes that we people in Parkdale have to bring our community back up to standard and to make it a community that has a mix of people; that has families and single people and people who have problems. But closing down Lakeshore will destroy that hope of Parkdadians. In the long run it'll have the effect, as Tony said, of creating a ghetto. I don't think that's what the province wants, and I hope you'll postpone closing



down the hospital until such a time as at least you can look at the implications from a planning point of view and from the community's long-term interests.

**Mr. Chairman:** Thank you very much, Ms. Stevenson. I have Dr. Duszta and Mr. Conway on my list.

**Ms. Z. Stevenson:** May I say something?

**Mr. Chairman:** Yes, of course.

**Ms. Z. Stevenson:** We have a lot of pent-up energy here. We haven't had our chance to speak for a long time.

**Mr. Chairman:** Very good. You have your chance now.

**Ms. Z. Stevenson:** There are a lot more people you are not hearing from, I can assure you.

**Mr. Chairman:** We have a limited amount of time. That always seems to be our problem. I am sorry; go ahead.

**Ms. Rankine:** My name is Jackie Rankine, and I am representing the Beaty Avenue Improvement Association. We sent a letter to your committee, outlining our concerns, and we came up with four recommendations that we would like to see implemented. The first is to keep Lakeshore Psychiatric Hospital open.

The reason that our street association is so concerned about this issue is that there are at least six and probably nine, group homes on our street, which is a small, residential family type of street. We asked the city of Toronto planning office to take a survey for us, and they found that within a 1,000-foot radius of our street there are 20 group homes.

Most of us feel that Queen Street Mental Health Centre is a part of our community; we have a responsibility to help people return to the community; and we fully support the efforts of community care and normalization that the province is moving towards. But we feel that the province is doing that rather cynically, because it seems as though the hospitals are being closed, the staff at Queen Street is being cut back and nothing is being put in its place.

These group homes are really dreadful. They are on my street; I can tell you what they are like. One building is a big old Victorian house—it is large, but it's just a house—that has 47 residents in it. The way they pack people in those buildings is to put three and four people in a bedroom, and that leaves one living room which is shared as the common room for these boarders.

There is no community after-care service

where people can go and spend their days, and we know that in many of the houses people live on welfare. Often the landlord is the trustee for the welfare cheque, so the landlord is making money out of people's sickness by taking the entire welfare cheque for room and board, leaving these people with \$5 a month to spend on their personal needs.

[6:00]

There is simply nothing in our community. We have already been defined by the planning office as being short on parks and recreational facilities for family people; for socially isolated people and chronically ill people, there is nothing. That's why we think there has to be a much better program of approved homes—not these unlicensed boarding homes—and that these approved homes should be located around their parent institution. We need some for Queen Street, for right now we are a dumping ground for Queen Street, Whitby, Lakeshore—all of them. If you want the data, I am sure you could get them from the city of Toronto planning office. It's really outrageous.

We would like to take this opportunity to ask, as we get really confused, to whom we should go about this problem. Some of these group homes are run by the Ministry of Health, some are run by ComSoc, some are run by Corrections, some are run by the city, some are run by private charitable corporations. Who is responsible? We'd like the province to set up an inter-ministerial committee and hold hearings on this problem, because you are turning Parkdale into a ghetto.

I am a tenant in a family home, and we have two kids in our house. What it means is that there is no other little girl on the street for the little girl in my house to play with; that's what happens when this kind of concentration occurs. That's not returning to normal life; that's driving families out and creating a ghetto in the city.

**Mr. Chairman:** Thank you very much. Anyone else? Mrs. Kuzmich?

**Mrs. Kuzmich:** I would like to add what I have seen across the street for the last 12 years. He was taking a patient from Queen Street; now, next door to him. All winter long I saw these poor people sitting on the bench, or on the stairs, from six o'clock in the morning. Queen Street takes the other patients and dumps them on to the whole area. We haven't got facilities; these people need professional help, and they are just getting worse. Ambulances and the police



come at all times at night to these places, and I guess this is going to continue until a few of them are burned, because there are fires almost every second night on the street in these bachelorettes. I don't think you should close Lakeshore and dump people in the places that they are not familiar with. They need help, because they are sick people.

**Mr. Chairman:** I have Dr. Duktza, Mr. Conway and Mr. Ramsay on my list and about seven minutes to cover that ground. Dr. Duktza?

**Mr. Duktza:** These are really comments. We have heard from a number of experts who have praised the latest move by the ministry to close the Lakeshore hospital as a wonderful new community psychiatry movement. We have heard now from a number of people who are involved and who have directly contradicted what the ministry has said. In fact, the decision has nothing to do with community psychiatry. It is an attempt, as one of you has put it, to dump more people into one particular area and to create a backward community.

I am commenting, because I am in agreement with what you have said, and from the beginning I have based my opposition to the closing of Lakeshore on two points. First, it's bad psychiatry to close a facility and throw people who are not well into a community without supervision and into group homes that have no standards; in fact, it creates backwardness in a community. Second, it's bad for the community of Parkdale. That's my second opposition. I want to differentiate, because they are both quite compatible. When you see how community psychiatry works under the guidance of the Minister of Health, it doesn't work very well either in the hospitals or in the community.

The answer here is perhaps threefold. First, we must make sure that areas like Etobicoke, Peel and others have a hospital and take care of their own patients, including the residents from those areas who would go to group homes either in the Lakeshore area or on the grounds.

Second, we must take care of our own patients here in Toronto at the Queen Street Mental Health Centre.

Third, we must have standards for the whole array of group homes which exist. Maybe the time has come for the Minister of Health to recognize that it is the responsibility of the Ministry of Health basically to provide the standards. No longer can the ministry simply, by discharging the patients from their care, discharge its responsibility

for the provision of psychiatric care to long-term patients.

In effect, the Ministry of Health, provincial mental health branch, must assume responsibility now and reverse the trend which has been going on for some time.

**Mr. Chairman:** Mr. Conway?

**Mr. Conway:** I think you answered my question. I wanted a profile of one of those Victorian buildings that houses 47 people. You've made a very good point and you've really answered my initial question; so I'll pass to Mr. Ramsay.

**Mr. Chairman:** Mr. Ramsay?

**Mr. Ramsay:** Mr. Chairman, I think everyone expressed his concerns very eloquently, but particularly Ms. Rankine. She hit upon a point of clarification, as far as I was concerned, and I'd like to follow up on it.

I was told, when I visited Queen Street—at least I believe it was at that time; it may have been when I visited Lakeshore, but I'm not sure—that the outpatients for Lakeshore were living in the Parkdale area and, because of zoning bylaws, they're not permitted to live in the Lakeshore area or in Etobicoke. Is that correct? I guess the point that was made to me at Queen Street, and I'd like clarification on it, is whether the Lakeshore outpatients already are in the Parkdale area?

**Ms. Rankine:** Some of them are. The planning office in its research for our street association found that there were some halfway houses for Lakeshore already in Parkdale. Our concern is that inevitably those people who are now living in the Lakeshore area will drift towards Parkdale, because the trend is that once you go into hospital you relocate close to your parent institution. If you're well for a few months and you have a crisis such as you're admitted to Queen Street and you go into Southwestern Service, then you look for a house close to the hospital. You go in for day care, and you can walk to the hospital. When you're on welfare, a streetcar ticket's a lot, et cetera. It's obvious.

**Mr. Ramsay:** The argument that was given to me, though, was these people are already there. You say a few. I was told most of them.

**Ms. Z. Stevenson:** Patients' services yesterday, I think, said that there were approximately 200 of the Lakeshore outpatients in the Parkdale area and that 50 per cent of the people in the outpatient program at Lakeshore live in the Lakeshore area. I think her statistics are probably the most reliable.

**Mr. Ramsay:** I was absent yesterday; so I wouldn't have heard that. Are there group homes for the Lakeshore area in Etobicoke?

**Ms. Z. Stevenson:** I'm not sure if there are group homes, but apparently 50 per cent of the outpatients are finding accommodation there. I don't think that there are. They're in private homes.

**Mr. Ramsay:** Coming from northern Ontario, I'm not aware of the problems of zoning and so on in the various boroughs.

**Ms. Adams:** I would like to supplement that. I was a social worker for the Children's Aid Society for three years in Parkdale before I was elected; a great many of our clients were either outpatients of Lakeshore or had psychiatric problems, and we referred them to Lakeshore. There are a great many creative outpatient programs they were able to use, particularly for alcoholic drug problems. I don't know if you've heard from the Children's Aid Society that serves that area, but Lakeshore certainly met a need that's there.

**Mr. Chairman:** Is there anyone else who would like to make a final comment?

**Alderman Ruprecht:** I just want to add one point in response to your question. I talked to Mayor Lastman two weeks ago, and he told me quite clearly that he felt that he did not want any group homes for people who came out of jails, for ex-convicts.

His impression was that North York doesn't have any people there who are ex-convicts.

Our feeling, of course, would be that people are coming from all over Metro. In fact, at the meeting that I called two weeks ago, it came out very clearly that a person was there from Peterborough. He said: "Oh, we know about Parkdale. Before we go anywhere else, we go to Parkdale." Some of you were there.

One of the basic approaches would be to create legislation that would permit group homes all over Metro, and not only permissive legislation in some segments which would ghettoize an area.

**Mr. Chairman:** You've all expressed a very legitimate concern. I should just clarify one point. The role of this committee is to make recommendations to the ministry with respect to the closing of Lakeshore Psychiatric Hospital. We do not have the power vested in the committee to make that decision. That, of course, resides with the ministry. But certainly your comments will be taken into account, I am sure, as the committee writes its report.

The committee adjourned at 6:10 p.m.

## SPEAKERS IN THIS ISSUE

---

Blundy, P. (Sarnia L)  
Conway, S. (Renfrew North L)  
Dukszta, J. (Parkdale NDP)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Kennedy, R. D. (Mississauga South PC)  
Lawlor, P. D. (Lakeshore NDP)  
McClellan, R. (Bellwoods NDP)  
Ramsay, R. H. (Sault Ste. Marie PC)

### **From the Ontario Public Service Employees Union**

O'Flynn, S., President  
De Matteo, R., researcher  
Paksi, Ms. P., President, Local 539  
Sneyd, G., President, Local 531  
Wood, S., chief steward, local 539

### **From the Parkdale area**

Adams, Ms. B., Alderman, city of Toronto  
Kuzmich, Mrs. N., private citizen  
Rankine, Ms. J., private citizen  
Ruprecht, T., Alderman, city of Toronto  
Stevenson, Ms. Z., community legal worker, Parkdale Legal Services  
Weatherup, B., Chairman, Parkdale Working Group on Bachelorettes





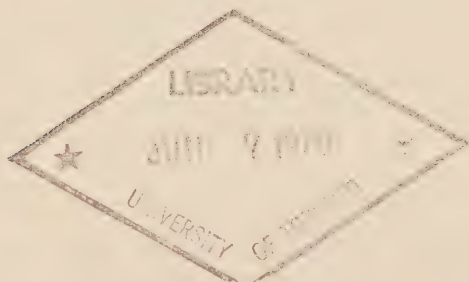
No. S-13

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Wednesday, May 9, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

WEDNESDAY, MAY 9, 1979

The committee met at 2:15 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

(continued)

**Mr. Chairman:** I think we will call the committee to order and move along. Our first witness is Mr. Howard Richardson, Executive Director, Ontario Mental Health Association. If you would like to come forward, Mr. Richardson? Do you have an opening statement, sir?

**Mr. Richardson:** No, I don't.

**Mr. Lawlor:** Could you describe your role and function for us, please, Mr. Richardson?

**Mr. Richardson:** The role of the association is as a member of the Canadian Mental Health Association in Canada. Mental Health Ontario is a voluntary, nonprofit organization operating through 33 local branches in Ontario. The primary objectives of our association include advocacy, social action, education, the prevention of mental illness and the direct service function through our local branches throughout the province.

**Mr. Lawlor:** I am going to make a general statement, and then you may comment on it if you wish. I have spent some hours reading a report on psychiatric services in Metropolitan Toronto. It was prepared by the Canadian Mental Health Association, or under their general auspices, and is signed by Audrey McLaughlin, who has previously appeared before us. This report was released in May 1977.

I was particularly interested in your global recommendations, particularly chapter four of this report dealing with community services. I think the New Democrats, but I suspect all members of this committee think a priority role, a central role must be given to the community aspect of the services in mental health. It has been abnegated or neglected in the past. You have crusaded in that particular direction. Your report is a reaffirmation of that basic position. But from the point of view of a layman, from my point of view, it is—I don't suppose the word is Utopia, but it is a partially idealized picture of what damn well should be, and what you want.

What your organization does, as I see it, is point the way and say, "If you want a system, you have to have it highly co-ordinated among all the factors in the community, not just psychiatric hospitals and general hospitals, but among general practitioners and all the social services. These things must all co-ordinate."

There is a total lack of that. We have asked for many years to bring this into being. We haven't seen much sign of it. As a matter of fact, in many areas things have deteriorated. Our position, therefore, basically is that it is going to cost money; you can't avoid that. If you are going to be of any efficacy in the field of mental illness, then you damn well have to do it. And if you don't do it, the consequences are going to be very grave for society as a whole, not just for those poor devils who are suffering from some degree of mental affliction.

So you outline in chapter four a considerable host of ideas. You call it the community alternative. For instance, you say on page 62 that "After-care is probably the least organized, least understood and least accessible part of the system." Further down the page you say, "The question as to who has responsibility for after-care is certainly not resolved." In fact, one issue frequently alluded to was whose responsibility after-care should be. You go on and list the social agencies and then you get to more specific problems.

To our knowledge, extensive studies in the efficacy of various types of housing alternatives in effecting a decreased rate of rehospitalization and maintaining the individual's independence has not been done in Metropolitan Toronto. However, many studies done elsewhere have indicated the alternatives in residential care to prevent debilitating institutionalization. You go through page after page of that.

In Metropolitan Toronto, there were approximately 30,000 individual inpatient and outpatient contacts in a six-month period. That's with your organization, I take it. Currently, there are approximately 536 residential settings and you have some fairly cryptic and disparaging remarks—quite rightly so on the evidence we've heard here—as to the state of some of those facilities.



It is very difficult to project need because of a lack of accurate statistics; even the statistics aren't in place. You really haven't got the figures at your disposal. There is a lack of accurate statistics and followup on discharged patients—you don't know what happens to them. It does not seem unreasonable to suggest that even by the most conservative estimates the number of appropriate residential placement needs to be tripled. And this was 1977.

On through this report, you give some case histories. You refer to this one. An ex-patient in a letter to the task force described her after-care experience in another type of boarding home. "We were seven women in a dismal room, with no sheets on the bed. Just a blanket underneath and one on top. I got out as fast as I could. But other unfortunate residents there are still quite sick, lethargic and apathetic. They thus accept this horrible situation without even a protest." And then you go on to point out the kinds of depression involved in mental illness. This acts as an inhibiting thing on people. Protest is exactly what they don't do. That's what the depression consists of—a failure to respond.

So you go through the role of police and the role of public health nurses and the lack of co-ordination and all these dedicated people nevertheless are unable to function within their tasks. You point all this out and you've done so for years and years.

Then you come before the committee saying while psychiatric hospitals have a place, and while there's a core population that has to be given cognizance to, nevertheless the emphasis placed on these hospitals is not what it should be, and tends to detract from them over against this global request or demand for an alternative service which, to me sitting here, is not forthcoming. It isn't there. If it were there, I don't think we would be sitting here today. But until that is in place, I put it to you it will be necessary to maintain these present facilities. Of course, I am particularly interested in this regard as the member from the Lakeshore area.

There will be a day, I trust, on which a hospital like Lakeshore will be closed. We'll rejoice in it because the people who are presently there will receive adequate and basic services and will be provided for. But as things presently stand, we're light years from that position.

Those are my basic thoughts. The position of the mental health associations coming before the committee tends to derogate from what I consider our immediate and overwhelming pressing task. The hospital must

be kept open for an indefinite period until these facilities are arranged for. This wonderful co-ordination we've heard about, other members, other witnesses, doctors who've appeared before us, with respect mainly on the ministry side, also put forward, without a hope in hell of seeing it achieved at least within a reasonable period of time for the very reason they want to close Lakeshore, namely, they're not going to give any money. So they're caught between two fires.

Would you care to address yourself to those issues?

**Mr. Richardson:** Mr. Chairman, yes I would. Thank you. I appreciate and I respect your observations on our report. I quite agree, in many instances it is very idealistic. However, the citations of neglect, gaps and cases which we named in that report—which our branch in Mental Health Metro named—are very realistic cases. However, the presence of those circumstances, in our opinion, do not necessarily justify the continuation of the Lakeshore Psychiatric Hospital. Those people in that facility could be far better, psychologically and emotionally, in community settings—that is, the least restrictive settings.

The literature clearly abounds with the fact that institutional settings do not encourage social, life-skill development very often. The very fact that the population of institutions has decreased significantly over the last 10 or 20 years in Ontario, and the readmission rates in hospitals continue to increase, suggests that the hospital setting is not necessarily the most appropriate setting. The fact is, we've not had the luxury of the alternatives that are in place and co-ordinated.

**Mr. Lawlor:** Do you mind if I argue with you a bit as you go along? You let me make a full statement. I'm quite prepared to do the same for you. On the other hand, the evidence we've heard, the necessity for the reinstitutionalization, the readmission rate, indicates to me just the opposite; namely, that adequate care wasn't given at the time. A little more attention paid might have very well done something to pre-empt this enormous readmission rate. It speaks to a policy in the hospitals of jettisoning human beings too quickly, in order to show very optimal statistics, of serving positions, et cetera, and under the impress of monetary restraints.

**Mr. Richardson:** Several years ago, an author by the name of Chetram Singh, of the Ministry of Health, published a study which clearly indicated that approximately 40 to 44 per cent of the patients in the existing, I believe it was 12 or 13, psychi-

atric hospitals, were simply there because there were no other community alternatives in which to accommodate them. We think that's pretty significant. I think the Ministry of Health thinks that's pretty significant.

**Mr. Duksza:** What was the percentage again?

**Mr. Richardson:** It was 40 to 44 per cent of the individuals in psychiatric hospitals were simply there, quite often, because there was nowhere else to go. Toronto, as I'm sure committee members appreciate, is a unique situation. The city abounds with services of one kind or another.

The Canadian Mental Health Association is not saying that we must replicate or duplicate or demolish these services and start all over again. Our support system philosophy and policy clearly rests with the proposition that a support system is based on human support rather than institutional-based support. There must be some cutting across of lines between institutions, planning agencies, such as district health councils, self-help groups such as the Ontario Patients' Self-Help Association in the province, which came about largely with the support of that report, sir, that you're reading from, and our association.

We are attempting a compromise, in that, yes, there is a role for a psychiatric facility for certain patients who require extensive psychiatric-medical care of one kind or another. But, yes, there's a greater need for an appropriate system, with appropriate legislation, and appropriate funding. It's no secret that the psychiatric hospitals branch, with a budget of \$160 million, is slightly different from the adult community mental health branch, with a budget of \$4.3 million. [2:30]

Therein lies the problem, despite the minister's philosophy that community health is a personal priority of his. I think he is trying to achieve that, but under very, very difficult odds I might add. As you well know, mental health and psychiatric services are simply not popular and very difficult to sell.

**Mr. Lawlor:** As things presently stand, are the patients from these institutions enjoying the support services, the housing accommodation, the therapeutic environment, that you are recommending and look forward to?

**Mr. Richardson:** I am sorry. Are patients in hospitals—

**Mr. Lawlor:** Are patients presently receiving, or enjoying, or having the utilization of support services once they leave the hospital? Yesterday we heard a lot of evidence

with respect to Parkdale, which is to some extent, they claim, becoming "ghettoized" in this regard. The evidence is they are derelict; that they are left really very down and out. Precisely the thing you are asking for is not being provided. I guess we are up against a political problem here, I am asking you what do you think the chances are of reaching any proximation of your relatively ideal goal?

**Mr. Richardson:** Perhaps by initiating a community referendum on mental health and social services; perhaps doing some realistic market testing of what the community really wants; perhaps putting the question to the communities in the province of Ontario as to whether or not people want to exercise their rights and responsibilities as health delivery stockholders. If they don't, that is their option. If they do, then they have an opportunity to participate with district health councils; with other planning bodies and so on.

We believe that that spirit of right and responsibility is increasing in Ontario and people are insisting, they are demanding, to exercise their rights and responsibilities. The Lakeshore hospital closure is but one very significant and important example. The expansion of the Whitby Psychiatric Hospital is another where volunteers and lay people, throughout the catchment area, are meeting specifically to propose more formalized planning structures between the community, the Ministry of Health, and the psychiatric hospital, to effect some realistic interface so in the years to come, in the next psychiatric hospital closure we are not faced with crisis management, but with more time frames and a realistic ability to put the appropriate services in place for people.

**Mr. Lawlor:** You find Whitby suspect, too?

**Mr. Richardson:** I find Whitby interesting.

**Mr. Lawlor:** No. In your report you use the word "inappropriate" for the east end of Toronto. In other words, you attack the continuation of the Whitby situation, as you do the other, in the light of these projections and desires and what you think is the fitting alternative. Again, I agree that it is the alternative. But I don't have any hope, or damned little, of seeing it brought to pass within the reasonable future.

**Mr. Richardson:** On January 13 the provincial board of directors went on record and unanimously passed a resolution to support the closure of Lakeshore. I have copies of that motion for the interest of the committee, Mr. Chairman. There was an important provision, however: that the range of suitable



alternatives that are necessary, such as co-operative housing programs, apartments, social rehabilitation centres, vocational programs and service co-ordination agencies are in place by September 1. Personally, sir, that is a desire; that is an ideal.

**Mr. Lawlor:** If I may be poetic about it, you see, you are whistling beside or somewhere near the Pollyanna tree, you know. You can do little dances around it. I have been around here a long time and watched the developments. I wish to God it would come to pass, but—all right.

Just one final thing: you have an enormous educational job to do, though, in the general public and that is probably your major function. The benefits arising out of trying to inform a citizenry and to remove that stigma must be monumental for you. Is that so?

**Mr. Richardson:** It clearly is in view of the problem I mentioned earlier that the whole field of mental health services and psychiatric services in general are not exactly the highest priority in this province. As I mentioned, the difference in figures as between the psychiatric hospitals branch and the adult community health branch are quite significant.

Having repeated our board's resolution, however, it has been with our support and our delight that the ministry has taken some leadership in effecting and creating a joint planning and a joint priorities structure and a mechanism specifically with regard to the outpatients at Lakeshore. It's my understanding to this point in time that there has been a number of proposals and recommendations and suggestions with regard to those alternatives and budgets for those alternatives which both Dr. Lynes and Mr. Jappy, I understand, are reviewing and perhaps by this time have approved. I am not sure.

**Mr. McClellan:** Before you continue, I think it would be helpful to the committee if Mr. Richardson would give us a copy of the resolution. I would ask the clerk of the committee if she would have it duplicated right away so that we could have a look at it and have it available as we question.

**Mr. Lawlor:** I won't press much further. As the member, I know the area better than most. I put it to you that these recommendations have come forward in a rather ad hoc and desperate way to the ministry. They are reviewed in the minister's statement to us at the initiation of these hearings. There are no commitments along the line at all. It's highly ambiguous even with respect to the alcoholics

unit about which they haven't got a clue as to where they could possibly locate it.

In my riding and I think in the environs of that riding I put it to you there are no community facilities available to meet even the minimal needs you have set forth. The whole bylaw structure, as has been pointed out, in Etobicoke and elsewhere, except for Toronto, is so designed as to exclude group homes, and people live in odd assorted rooms throughout the Lakeshore area. In other words, there is no accommodation available to put a roof over their heads to start with. Where they can possibly locate a half a dozen of the units at the hospital, no one knows at this time. The task forces have not been able to come up with any. There is some talk of using an old school with respect to retardation. But even if they could find one, the renovation of the school would be enormously costly to turn it into a hospital, probably more so than doing the first phase of the capital development that I am requesting at Lakeshore.

Four or five years ago—and you know this well because I was deeply involved with your association at the time on the child and adolescent care unit, which is not under Health but under ComSoc—16 or 17 highly capable people formed a committee of citizens right throughout Metro in order to locate an alternative facility.

There was some problem with a young boy being referred to by the courts, if you remember, getting into the adult units. They found an abandoned police station. It was the only location physically in the geographical area and that unit is there today and will remain there on the Lakeshore site because there is no alternative. It's all right for you to set forth what is needed and what is desirable, but the hard fact of the matter is that the facilities that you propose simply aren't available.

**Mr. Richardson:** That is true in view of the restraints and the cutbacks that this ministry, like other ministries, has been forced to realize. With a budget of slightly in excess of \$4 billion, when one computes what the adult community mental health program thrust of the ministry is, it is simply ridiculous to make those kinds of comparisons. What we have is a ministry of casualties, a ministry of sickness, rather than a Ministry of Health, forced by circumstances and crises to deal with that.

**Mr. Lawlor:** You are right.

**Mr. R. F. Johnston:** Here is another crisis. I don't know why you are happy about this supposed time process.



**Mr. Richardson:** Excuse me, Mr. Chairman, I did not indicate nor do I support any degree of happiness about anything as far as community mental health programs are concerned in Ontario. Let me make that very clear. What we do feel very strongly, however, based on the evidence and based on our experience, is that the hospital setting is not necessarily the most appropriate for a lot of people. As a result, we often see those who don't make the hospital treatment program being transferred to homes for special care, for example, which is a far more restrictive setting as compared to a group home environment where people can choose when to have lunch or dinner or when to go shopping or whatever.

What we are talking about is the community closest to a person's home, with friends and with support mechanisms, and Lakeshore has clearly demonstrated this with its community outreach programs. You will note from our resolution that we have proposed that the Lakeshore staff be transformed, if you will, into community placement officers. We feel that there should be hospital staff or people in the community whose very job it is to keep people out of hospitals. We think that many of the alternatives I have mentioned are in fact in place in Toronto and other places. People in North Bay, Timmins, Kirkland Lake, Cornwall and Ottawa would disagree with me on that statement, and I am inclined to agree with them with regard to after-care and rehabilitation. But it is a matter of resources and a matter of a good planning mechanism to do that. We have neither at this point in time.

**Mr. Lawlor:** Mr. Chairman, I may ask to come back in, but I defer now to other members of the committee.

**Mr. McClellan:** May I just have one supplementary just to clear up a confusion in my mind? You presented us, Mr. Richardson, with a resolution of your board of directors, dated January 13, supporting the closure of Lakeshore conditional on other grants being achieved, but the closure was not announced until January 20.

**Mr. Richardson:** I believe that closure was announced prior to that.

**Mr. McClellan:** Am I wrong?

**Mr. Richardson:** On January 7, 9 or 10, shortly prior to that board meeting.

**Mr. Duksza:** I understood actually from the administrator and the medical director—and they said this repeatedly here and when I met with them—that they learned of it

on the date it was announced, which I think was January 20.

**Mr. McClellan:** January 20.

**Mr. Richardson:** I believe there were several announcements. There was a very small article in a newspaper, the Star or the Globe and Mail, I believe, and there were one or two other more major announcements at that point.

**Mr. Duksza:** It sounds like rushing in where angels fear to tread.

**Mr. Richardson:** Remember we are in this business, so it wasn't exactly a surprise to us.

**Mr. McClellan:** How did you learn of the closure?

**Mr. Richardson:** We learned of the closure primarily through gossip lines initially.

**Mr. McClellan:** From the ministry?

**Mr. Richardson:** No, not from the ministry. Secondly, we learned of the closure through a very small, innocuous 10- or 12- or 15-line statement in one of the local newspapers.

My understanding, if I may, Mr. Chairman, is that the staff at Lakeshore are not totally unhappy with the move in principle.

**Mr. Duksza:** I think you are right. Nine out of 10 are unhappy, but one out of 10 is happy. If you consider that majority, then this is so.

**Mr. Richardson:** The lack of consultation, the lack of advance notice and the lack of participation in that decision is a very real concern. I personally agree with that.

**Mr. Duksza:** For your information, I think we had a rather extensive presentation yesterday by the union that represents probably three out of four people. I think they were unanimously and uniformly dissatisfied with the decision. I am afraid the gossip is part of public relations.

**Mr. Richardson:** That is expected.

[2:45]

**Mr. Duksza:** Expected, but it doesn't contradict what you just said, nor the gossip that you heard. I agree entirely it is expected. Maybe they feel as they do for two reasons: one, the job; second, concern for the patients. But it doesn't change the fact that what you just said is not quite correct.

**Mr. Richardson:** For those people losing their jobs I would agree, sir.

**Mr. Duksza:** So are you in agreement that the majority of people in the hospital would prefer those who had worked there?

**Mr. Richardson:** No, I am not.

**Mr. Duksza:** Where did you get your information, Mr. Richardson? I am curious.

**Mr. Richardson:** Through talking to people at Lakeshore, through members of the committee.

**Mr. Chairman:** Dr. Duksza, you are on later on and perhaps you can get into it at that time. Mr. Leluk.

**Mr. Leluk:** Thank you very much, Mr. Chairman.

I have four short questions I'd like to pose to Mr. Richardson. Do you feel the Ontario government is moving in the right direction with its deinstitutionalization program and simultaneous support and additional funding to community-based programs?

**Mr. Richardson:** I understand it's a primary corporate priority of the ministry, yes I do. I personally, in representing my organization, certainly would agree with the deinstitutionalization policy; along with a clear emphasis on community alternatives to institutions, quite apart from cost factors; yes.

**Mr. Leluk:** Does your office, or say any branches of the Canadian Mental Health Association, communicate with any ministry of this government in any way?

**Mr. Richardson:** Yes, we do, weekly.

**Mr. Leluk:** Fairly regularly; and do you feel that is satisfactory as far as communication with the government goes or would you like to see that expanded?

**Mr. Richardson:** I believe the time available to ourselves in the association and the ministry staff has been adequate to the extent possible. I personally would like to see a more formalized structure which has a bit more frequency and system.

**Mr. Leluk:** Some type of liaison committee or something of that nature?

**Mr. Richardson:** At least the identification of specific individuals who would—and this is not new, we have discussed this before; I think something like this might come about.

**Mr. Leluk:** Do you feel there is an overlap of services, say between the Lakeshore Psychiatric Hospital and some of the units in the general hospitals that serve that catchment area; and if so, why?

**Mr. Richardson:** I cannot adequately answer that because I am not aware of the specific caseloads of the psychiatric hospitals in relation to any possible duplication by psychiatric units of the general hospitals. What I do understand and what I have been advised is that the closure of Lakeshore will undoubtedly cause some pressures on the general hospitals and the psychiatric units.

**Mr. Leluk:** On the general hospitals.

**Mr. Richardson:** I am not aware, however, of the numbers of people involved, unfortunately.

**Mr. Leluk:** I see. Does your organization support closing of the Lakeshore Psychiatric Hospital? I know they recently passed a motion, but do you feel the hospital should be closed and are you supportive of the minister's position in this regard?

**Mr. Richardson:** With contingencies, yes.

**Mr. Leluk:** And what may some of those contingencies be?

**Mr. Richardson:** That a suitable alternative for each and every outpatient is planned for and in place prior to the closure.

**Mr. Leluk:** Prior to the closure. I don't have any other questions, Mr. Chairman.

**Mr. Kennedy:** Could I get a supplementary on that? Could you say now that each and every patient in that area is provided with that facility? Is that over and above what's taking place now?

**Mr. Richardson:** That's a very good point. I am not sure the approximately 1,500 people would require services and programs in addition to what's currently in place in Metropolitan Toronto or in that area.

**Mr. Kennedy:** Maybe the additional \$1.3 million will provide something along that line, if indeed that isn't adequate service now.

**Mr. Richardson:** I couldn't equate it to a dollar figure.

**Mr. Kennedy:** Thanks, Mr. Chairman.

**Mr. R. F. Johnston:** I am having a great deal of trouble, as somebody who has been involved in community development work in the past, in understanding how you think the process that has been gone through in the Lakeshore area in determining needs is adequate in terms of long-term, comprehensive, home-care support, or in-the-community support to the mental health patients we are going to support in the community, given that your organization has documented so thoroughly in the past many of the drawbacks and a lot of the failings. I have been involved in a session you led in Whitby, which was trying to pull people together, from psychiatric hospitals and community and general hospitals, to talk about how the network worked. I came out of that two-day session—I was only able to be there for one day during which we did a role-playing exercise to study a patient who fell between the institutional gaps—and I came away with two major feelings: One was that the people



from institutions were blindly presuming everything was handled well. I thought they had a very haughty attitude toward it; and two, that people like myself in the community, who were trying to deliver community-support programs, felt there was no major co-ordination.

That was in the Durham region, not Metro, so I am not able to speak to it; but a lot of the evidence we have been receiving here over the last weeks indicates that yes, there are a number of programs in Metro; and yes, Metro has more services than any other area; but my goodness, they are not co-ordinated.

I don't think we can say, although the minister may himself say he has some sort of commitment to this movement, that there has been a major move in that direction. There has been no definition of the steps that are required. What do we do with boarding houses; what kind of standards of care, even just in terms of housing, are needed in the city; and how do we go about ensuring that various communities will provide this kind of housing? What we are presented with is a closing—boom; and then let's work out some details of this by September. Details for what I can't help feeling is a very complicated process which it will take a number of years to work out properly.

Why experiment with these people in this way? Why not announce an intention to close this kind of hospital, to cut it down, or turn it primarily into a resource for outpatient care in that area or whatever; and then plan the process for developing a solution over, say a two- or three-year period, some period which is reasonable; but not by September?

I find it very difficult to understand how you feel good about that, but you seem to. You say, with certain reservations, it can be in place by September. I would rather see the structure developed first; then start to move people out of the hospital, then start to move a hospital and disrupt the hospital; but you don't do it in this fashion. Can you comment on that? I am very disturbed by it.

**Mr. Richardson:** We are not happy about it either. I have to repeat that it is not with the total satisfaction and joy of our association that people who have some psychiatric disability, if you will, are in need of anything, let alone that that need results from the closure of a hospital. The same thing happened at Northeastern Regional Mental Health Centre; the same thing happened at Goderich Psychiatric Hospital; and I personally think the same thing is going to happen again. We are not in disagreement,

and I sense from your comments that you are not totally in disagreement with the closure of a costly, treatment-questionable institution either.

**Mr. R. F. Johnston:** No.

**Mr. Richardson:** It's a matter of the process and the timing.

**Mr. R. F. Johnston:** Yes.

**Mr. Richardson:** The September 1 deadline was not the Canadian Mental Health Association's deadline.

**Mr. R. F. Johnston:** Yes, exactly.

**Mr. Richardson:** We have been invited by the ministry to participate with a co-ordination and planning group. We are doing the best job we possibly can. It is my understanding, as I mentioned earlier, that a number of well developed, well planned proposals have now been given to provide for alternative services to those outpatients. It is our hope that at the time when the hospital is completely empty, each and every one of those individuals will be adequately placed in some form of treatment program. Our job, however, is to do some market testing with the consumers. Very few of the patients, to my personal knowledge, have been involved in the process. That we feel is part of our job and that is what we plan to do, to work with them and the Ontario Patients Self-Help Association.

**Mr. R. F. Johnston:** I agree with what you said; I don't necessarily feel that you need the institution in general, as compared with the community support, in this case. On the other hand, I am not sure that this is the institution I would choose to close because of its record. Again, I can only compare it with my knowledge of Whitby.

My impression of the mental health system is exactly what you said, it's not a mental health system at all. It's a mental illness system. It's not preventive and it works by crisis. I am concerned that there is a huge proportion of people who receive psychiatric care who receive no further support in the community at all. They don't come into our network. They run to their own psychiatrist perhaps, more than likely their own GP maintains a contact, but they fall outside of our service structure.

The people from Parkdale were really crying out to us yesterday and saying, "Here we are, we aren't opposed to having these people in our community, we welcome this kind of thing in our community; but it's now destroying our community fabric in the sense that there is no role any longer for the single-family unit on some of our streets." They are really being disrupted, and, "We are bearing



the burden of this; don't put any more of this on us without looking into it seriously."

I agree with your figures; you say you have got a ministry—I forget how many—100-and-some million dollars that is going into the maintenance of institutional care? What was it?

**Mr. Richardson:** It is my understanding that the psychiatric hospital budget in the province of Ontario is approximately \$156 million.

**Mr. R. F. Johnston:** Okay. So you've got \$156 million that has been going into that and you've got \$1.3 million extra which is going to be promised for this kind of care. And yet it seems to me that those of us who are promoting community care approaches are no longer saying this is necessarily going to be cost-effective. It may be as expensive to provide care in the community, or even more expensive, than in the hospital. So here we are closing down this hospital—a large expense to maintain, and I admit that—and talking about putting in \$1.3 million as a substitute for its care in essence. That's not exactly fair because part of it is going to Queen Street as well. How can you feel that that's adequate, and the timing is adequate?

I wish your resolution had said: "We will approve this kind of closure of this hospital but not under the strictures you're putting on us. The process cannot disrupt people in the hospital; cannot disrupt the community, as they are now doing to Parkdale; you must have a much longer planning process and a commitment to large amounts of money, if you realistically expect the community to handle these kinds of services."

I would have much preferred to see that than this, which, in my view, gives the ministry carte blanche. What's happening at the moment is people are being laid off now, people are being moved now on the presumption that it is going to happen. Unless this committee can come up with some sort of recommendation—which I don't think it's going to—to convince the minister that he shouldn't do this in this fashion, it's going to happen by September. Then your little clause, that these things should be in place, is going to have no effect; it's going to happen. That's my major concern. I really wish you could've come out much harder.

**Mr. Richardson:** I am not sure that it's a little thing in terms of the contingency. When the minister makes a commitment to close something, we expect him to make good his plans. The question of reality and practicality around the probability of doing that is questionable obviously to anybody. How-

ever, we expect it to happen. The Hospital Council of Metropolitan Toronto has been attempting to be a co-ordinating group for the last several years. The minister's problem, as he has stated on a number of occasions, is it's like coming together with six or seven different countries. Well, I am sure he is going to deal with that problem. He must deal with that problem now.

I think it has been pointed out it is not necessarily a question that the services don't exist in Metropolitan Toronto, but very few people have any knowledge and intelligence about the interface, the cross-sectional relationships of a number of services and programs. For that reason we identify service co-ordination groups, such as Community Resources Consultants in Toronto as an extremely vital and important component of the process that is underway right now. But given the fact that the people that come to us, that write letters to us, that call us, ex-patients, existing patients, are saying that the hospitals are not the appropriate place for them. This relates also to discharge policy which, in our opinion, my personal opinion, needs to be tightened up considerably.

[3:00]

**Mr. R. F. Johnston:** The readmission figures indicate that it is not being dealt with in the community either. It's not being done in the hospital properly and it's not being done in the community properly. I don't like to see the problem aggravated.

The other thing is the community development question in terms of approach to things. What I dislike about this as a community development organizer essentially is that I see a crisis being laid on the community—dollars being held up in the air as a means of, in my view, quietening down the resentment of community groups that have been working with that hospital, and you have them come together on their own and together to try to get part of those bucks.

The great thing that does is make them accept the initial concept. That's a really very clever approach, in a cynical way, by the ministry. But it gets them, darn it, to compete for things and sets up a situation where they don't do it in the long-term interest. They do it in their immediate interest, with a very short-term interest, based on their own individual experiences.

I don't think the time has been put into this, given that we are going to be meeting with Dr. Lynes on Monday, to get some idea what's happening here; there has not been enough chance to get the ministry to step back from it and say, "Okay, what's the real situation; or what is, in fact, the network

that is out there? Where should the emphasis be?"

The process that has been set up is one which, in the long run, is going to hurt, and I predict that in the long run you are going to come back and say, "Damn it, we were forced into rushing this thing and the network that was established did not have all the right priorities, was not set up adequately and we mustn't let that happen again." What I want this committee to do is to say to the ministry right now, it still doesn't have to happen this way; let's extend this full planning process and make sure that we aren't just rushing this thing through.

**Mr. Richardson:** Mr. Chairman, I'd like to clarify perhaps an impression, either through my comments or through certain assumptions by members of this committee, that the Canadian Mental Health Association, Ontario Division, has assumed a rather reactionary stance to the closure of Lakeshore. It hasn't.

**Mr. McClellan:** It's assumed an anticipatory stance.

**Mr. Richardson:** The community consultation process over the last two to three years, which has included legislative review, which has included putting together principles, assumptions and recommendations regarding community support systems—I have a copy I'd like to share with you—clearly outlines the principles of deinstitutionalization, the principles with regard to less restrictive settings, the principles with regard to interface of institutions, et cetera, which have been reflected in my comments and have not been in anticipation of a Lakeshore closing or any other hospital, for that matter. We are trying to look at community mental health services as collectively as possible, given the circumstances that a hospital closure obviously creates crises, obviously creates problems. We are part and parcel of that problem and we are trying to work with it as effectively as we can.

**Mr. R. F. Johnston:** I guess I just wanted you to take a stronger position on this, making sure this is—

**Mr. Richardson:** I am quite sure that our positions regarding the ultimate decisions and the layout, if you will, of Lakeshore will be quite strong, if our expectations are not met, and if they are not without some very good reasons.

**Mr. R. F. Johnston:** How do we stop the process? How do we repair the damage if it is done? I just think that the—

**Mr. McClellan:** What are you going to do if your conditions aren't met?

**Mr. Richardson:** I guess I'd have to put that question back to the government too. Being a voluntary, non-profit organization, we have no vested interests, and I must emphasize that. We have asked the same questions throughout the province. When I mentioned the community referendum earlier, I wasn't being facetious. It's time that people in communities are either ready to put up or shut up about community mental health care. And it's been the low thing on every totem pole that I am personally aware of. It's time the government, the communities, and my own organization faced up to that reality, or the blood of the mentally ill is on our hands and the government's.

**Mr. R. F. Johnston:** I know I am going on too long here, but I don't agree with that approach to finding out. I would say that kind of mass education required for the major ignorance about mental health issues out there also requires time. You wouldn't want to put this referendum to the people by September, would you? I don't think you could mount your case properly by then.

**Mr. Richardson:** Accepted.

**Mr. R. F. Johnston:** If you're going to do that sort of thing you should get that groundwork done first, so we can deal with these things, not on a crisis basis like this. Our whole mental health system has been doing that. The cutbacks everywhere in the health system are forcing us to do that, and it's just the wrong way to deal with health care.

**Mr. Duszta:** Mr. Richardson, clearly the Ontario division of the Canadian Mental Health Association, in your own words, is committed to the community psychiatry approach in its very fullest, by which you mean deinstitutionalization, provision of alternative services in the community, more general acceptance and knowledge and experience of mental illness. All of those things are part of community psychiatry.

Do you believe closing the Lakeshore is a significant step towards implementing those principles?

**Mr. Richardson:** Dr. Duszta, I think community psychiatry can be carried on anywhere, as I'm sure you would agree, not necessarily within an institutional setting.

**Mr. Duszta:** I agree it can be carried on. The question, I suppose, is where it is carried on, what kind of services and for what kind of individual. Could you comment on it, because in a way, I was left with the impression from what you are saying that though there has been a certain



lack of planning, a certain lack of co-ordination, nevertheless the closing of Lakeshore Psychiatric Hospital is a significant move towards community psychiatry.

**Mr. Richardson:** As you know, there is a very exciting research project being carried out in Madison, Wisconsin, where certain segments of the institutions have closed, some totally, and the outpatient psychiatrists are now dispensing treatment and drug therapy on the job to patients or wherever they happen to be. They visit their homes, they talk to them during coffee breaks in the morning or in the afternoon, or during their lunch hour for that matter, or after work. They're getting very good results because it combines lifestyle necessities and lifestyle demands with good psychiatric treatment, therapeutic treatment.

**Mr. Dukszta:** I think that's a very exciting project, but of course you must be aware, while we are talking theoretically, Wisconsin has more psychiatric beds per thousand than Ontario. Are you aware of that?

**Mr. Richardson:** Their bed ratios are greater than Ontario's.

**Mr. Dukszta:** In effect, there are more patients in bed in Wisconsin, in spite of this wonderful project, which by the way, happens to be largely oriented towards middle-class individuals. I happen to have partially read it. When you say work situation, I think, like the typical worker shown to Teng Hsiao-Ping on his visit to the USA, he is an executive who makes \$34,000 a year. That was a typical American worker. While that particular project deals with a number of interesting aspects—

**Mr. Conway:** What did you see when you were in China?

**Mr. Dukszta:** Don't interrupt. You came late, too.

The project which Mr. Richardson brings forward is a very interesting one. I think it's a very limited one and applicable to some and not to other types of patients. The type of individual who is helped by this sort of thing, of course, most of the time is not in the equivalent of Lakeshore Psychiatric.

Are you aware of the kind of patients now admitted who tend to be long-term patients in Lakeshore Psychiatric Centre?

**Mr. Richardson:** Yes. I'm quite sure, given the opinions of some of the professional doctors who work there, that a large number of their outpatients could not be treated anywhere else except at the hospital.

**Mr. Dukszta:** Do you accept that?

**Mr. Richardson:** Personally I don't, because I haven't seen the evidence to suggest the alternatives.

**Mr. Dukszta:** Why do you not accept that?

**Mr. Richardson:** Would you not agree that community psychiatry could go on with the outpatient population in places other than a hospital setting?

**Mr. Dukszta:** Yes, I agree. That's a general statement like motherhood, with which I am in total agreement.

**Mr. Richardson:** It's a real statement. It's happening in Ontario.

**Mr. Dukszta:** What do we do with the people who are now in bed in the Lakeshore? Do you think this individual can be treated in a community?

**Mr. Richardson:** I understand the bed patients are being directly transferred to other facilities.

**Mr. Dukszta:** Of course, there is no movement to the community by closing the Lakeshore. They are merely coalescing two hospitals into one larger institution. Regarding that I will ask you later what you consider an optimum size, since you represent a very important organization in terms of perspective, salary and everything else. But back to where we treat those individuals. You have just said, "Close it and we'll treat them in the communities." Let us deal with the individuals who are now in bed in Lakeshore, besides the ones who are being transferred, where can we treat them, in your opinion, Mr. Richardson?

**Mr. Richardson:** I think you are aware of the array of alternatives in the Lakeshore community that exist now.

**Mr. Dukszta:** You consider that perfectly adequate at the moment?

**Mr. Richardson:** I can't say it's perfectly adequate.

**Mr. Dukszta:** Your report said that it is inadequate, but I am also interested in certain contradictions between your opinion and the report.

**Mr. Richardson:** That's right. There's certain data and certain evidence in the psychiatric services report which suggests that a large number of people do not have access to psychiatric treatment and services.

**Mr. Dukszta:** You're saying it's adequate—

**Mr. Richardson:** That was done prior to the closing of Lakeshore, by the way.

**Mr. Dukszta:** I think it's May 1977. Besides the McKinsey report, which is much more forward looking in terms of update, it



is probably as comprehensive as we can get at the moment. Has there been a change in the association's opinion to such a degree that that report is no longer applicable?

**Mr. Richardson:** To my knowledge there have been no supplementary amendments to that.

**Mr. Duksza:** At the moment you stand by it—no, you personally don't stand by it, but obviously the association stands by it.

**Mr. Richardson:** That's right.

**Mr. Duksza:** The association's stance is there is no adequate provision of community-based psychiatric services in large metropolitan areas.

**Mr. Richardson:** I don't think the report says there are no provisions.

**Mr. Duksza:** No adequate provisions. Of course there are provisions—my God, you can walk up to any emergency room. I said no adequate provisions to deal with most of the psychiatric problems in the communities.

**Mr. Richardson:** I think the existing array of services do not adequately meet the demand. I think that's correct.

**Mr. Duksza:** If we wanted to meet it, what would be the time schedule to build the alternative psychiatric services in a community like Etobicoke, Peel, and others? Let me rephrase the question. What do you think should be done? We could allow ourselves to be a bit theoretical. The committee has a number of responsibilities and one of the responsibilities is to think of alternatives. That is what we fondly think we can do.

So let's think in that theoretical perspective. After all you are a theoretician, not a practitioner, so it might be much easier for you to be theoretical of alternatives.

**Mr. Richardson:** That must be obvious. Perhaps an alternative would be to give every patient a credit card, not for \$120 a day which it costs, but perhaps \$50 a day or \$75 a day, and to have each patient assigned to, or relate to or supported by hospital staff of one kind or another, and in fact work in the community. In fact be in the community with regard to vocational training, with regard to banking, with regard to finding a place to live. That in part relates the notion of the board which suggests that hospital staff should be identified as liaison officers, as alternative hospital placement people, if you will.

**Mr. Duksza:** Mr. Richardson, on the points you have made. Credit cards, or whatever system you want to say, means money from the government, which presumably once a change in government occurs would be easy

to implement. Then you say the individual has to relate to staff. What kind of staff, and do we need more if we are going to close the psychiatric unit?

**Mr. Richardson:** Dr. Duksza, I am not, as you obviously know, individually familiar with the staff at Lakeshore. I can only respond to your question generally.

The social, vocational, recreational, social work, psychiatric and psychological staff, and the corps of volunteers that work at that hospital, and many other psychiatric facilities, seem to be the most appropriate people to be instrumental in helping people move from a hospital to a community setting and living as normally as possible.

**Mr. Duksza:** So you are saying the same as the second part of your Ontario division's motion; that they should be employed in the community. Of course, you are aware that they have to move to Queen Street because in effect the patients are not being discharged into community, so we would have to in effect hire some more, say three to four hundred more people to deliver the work that you envisage at a significant cost, of course.

**Mr. Richardson:** I wouldn't anticipate hiring more people; I wouldn't know what the employment pattern would be. I'm not sure what the numbers of appropriate staff at Lakeshore would be to be deployed that way.

[3:15]

**Mr. Duksza:** Mr. Richardson, are you talking now of extra people? Because if you are proposing a system you must know how much it is going to cost and how much time it will take to implement it.

**Mr. Richardson:** You asked me what my suggestions were here at this meeting today. I am obviously not prepared to give you a detailed response to the methods, the procedures, and the costs.

**Mr. Duksza:** I gathered that. You throw in this thing about the Lakeshore Psychiatric staff working in the community rather lightly, because you also must be aware but have forgotten that they have to in fact take care of their own patients which are going to be transferred to Queen Street.

Now, on work. You say there are sheltered workshops, there is occupational therapy, there is industrial retraining, industrial workshops et cetera. Are you satisfied that there are adequate provisions for those things at the moment?

**Mr. Richardson:** Again I am not personally familiar with all of the services in the

Lakeshore community and the catchment area, including Hamilton and Metro Toronto.

**Mr. Duktzta:** Are you aware of how many are employed in the sheltered workshops? Are you aware how many?

**Mr. Richardson:** In which sheltered workshop?

**Mr. Duktzta:** Any. How many sheltered workshops there are and how many people actually are involved in them, out of an outpatient population which is now calculated, with various groupings, as 1,800?

**Mr. Richardson:** No, I'm not aware of that.

**Mr. Duktzta:** I think less than 10 per cent.

**Mr. Richardson:** I'm sorry, I didn't hear the response.

**Mr. Duktzta:** I would say less than ten per cent, at the most, and that's stretching it a bit. There is probably one sheltered workshop in Queen Street Mental Health Centre at the moment and the Jewish Vocational, which takes patients from right across Metro. There are very few things like that. So, in effect, to create this would need three years in planning and a significant amount of money. Are you aware, Mr. Richardson, that you do not create a sheltered workshop for industrial training in a span of two months?

**Mr. Richardson:** I'm not sure what your argument is. Are you saying—

**Mr. Duktzta:** I am just saying you have no idea about what you're saying if you were talking about creating industrial workshops by September.

**Mr. Richardson:** I am not sure, Dr. Duktzta, whether or not you were saying that the Lakeshore facility is adequately meeting those needs and that its closure in fact is going to triple or quadruple the—

**Mr. Duktzta:** No. I am discussing moving to communities. The moment you do that ex-patients who have been taken care of in the beds have to be taken into the community. This means you have to give them a bed to sleep in because they have no home, you have to provide them with someone to supervise them, you have to give them money and you have to provide them with work. That's what I'm saying. Do you think this can be done immediately, Mr. Richardson?

**Mr. Richardson:** I don't think it can be.

**Mr. Duktzta:** I love your submission. No factual basis but it's a lovely theory.

**Mr. Richardson:** Of course I don't think it can be done immediately. I don't think I ever made that presumption.

**Mr. Duktzta:** So, in effect, when would be your estimation to create this type of program, how long would we need? I won't ask you about money this time.

**Mr. Richardson:** For the community of Metropolitan Toronto I could not adequately judge that. I can only guess, based on other experiments throughout the province and literature which suggest anywhere from three to five years to meet 50 per cent of the need.

**Mr. Duktzta:** You're quite right, that's what we're talking of. So if we had just made the decision—this committee, the ministry, you or other people—to create a community-based psychiatric program in the area of Etobicoke based on those facts, that we need the money, supervising staff, work and a place to live; it would take three to five, I would say five to 10 years, to realize. But your figure is as good as any, three to five years. We would have to keep Lakeshore open until this occurs, wait a couple of years and plan it as time goes along and invest, as other experts have said, an enormous amount of money into this program. Would you not agree roughly? I'm paraphrasing of course much of what you said.

**Mr. Richardson:** Not altogether accurately.

**Mr. Duktzta:** Excuse me, which wasn't accurate, Mr. Richardson? Which wasn't accurate?

**Mr. Richardson:** I think you've talked about the community of Etobicoke.

**Mr. Duktzta:** Excuse me, which was inaccurate? I'm sorry.

**Mr. Richardson:** The community of Etobicoke versus the outpatient population at Lakeshore.

**Mr. Duktzta:** No, we're talking of creating what I outlined. I asked you for a theoretical perspective of creating a community-based psychiatric program.

**Mr. Richardson:** Yes.

**Mr. Duktzta:** And you have suggested there are four points. I agreed this is excellent, forward looking, then we started to talk about—

**Mr. Richardson:** Based on our motion, of course, and based on the closure.

**Mr. Duktzta:** So there was no inaccuracy when I said to create something like that before we can change our approach, to revolutionize our province in psychiatry, would need three to five years. That is what you said, is that correct?

**Mr. Richardson:** We seemed to change and revolutionize the closing of Lakeshore to a



very comprehensive program of community psychiatry in Etobicoke, and I think it's a great leap you've just made.

**Mr. Duktzta:** The Lakeshore catchment area, let me correct it. Three to five years, you said?

**Mr. Richardson:** Comprehensively for everybody, I would have to estimate that.

**Mr. Duktzta:** Then I was not incorrect when I said that. I was trying to paraphrase, in my imperfect English, what you were saying, but that is what you were saying, Mr. Richardson. What you were saying is the planning, in fact, has not occurred, it cannot be done, to implement—

**Mr. Richardson:** I think your inaccuracies, Dr. Duktzta, were taking my comments relative to Lakeshore and applying them generally across the board to a community psychiatric model in Etobicoke.

**Mr. Duktzta:** I am only talking of the Lakeshore. You mean they do not apply to Lakeshore, that this case is quite different?

**Mr. Richardson:** I'm sorry, I just—

**Mr. Duktzta:** Could I just come back to the patients in the Lakeshore? I asked you this question; maybe we could just pursue it for a short time. Do you know what kind of individuals they are? Can they be treated in the community?

**Mr. Richardson:** I can only tell you that some of the staff I have talked with at the hospital and people on the outpatient committee, after reviewing confidential case data, clearly indicate that a large percentage of the outpatients could very well benefit from adequate community placements of one kind or another which, as I said earlier, Lakeshore has exerted great leadership in already doing. The DARE program for example.

**Mr. Duktzta:** Do you mean inpatient or outpatient?

**Mr. Richardson:** Outpatient, sorry.

**Mr. Duktzta:** The outpatients are already, of course, mostly in community. Which group are you talking about?

**Mr. Richardson:** I am referring specifically to the outpatient population, which creates demands on the existing system, et cetera.

**Mr. Duktzta:** But, in some sense, they live in community already.

**Mr. Richardson:** Yes, that's right.

**Mr. Duktzta:** They live in the community. Many of them use the network, they still attend the hospital for their basic medication. So we are merely talking of shifting the outpatient to other resources away from Lakeshore. That could be done, I agree with you.

The fact that they are linked to a hospital means they would lose that important link. But I was talking of inpatients. You said about 40 per cent of the individuals in Lakeshore could actually be in the community now.

**Mr. Richardson:** No, I didn't. I referred to a study by Dr. Chetram Singh who reported that of the 12 or 13 psychiatric hospitals in the province approximately 40 to 44 per cent could benefit from some kind of community placement and they were in hospitals because there was nowhere else to go. I did not refer to that statistic as applying to Lakeshore.

**Mr. Duktzta:** Actually there's some question of that. Back to the patient who is in bed in the Lakeshore: Do you think we could actually manage to take that individual and put that individual in the community?

**Mr. Richardson:** The inpatient?

**Mr. Duktzta:** The inpatient I'm talking about now.

**Mr. Richardson:** My understanding is that the needs of the inpatients at Lakeshore are specifically being planned for at both Hamilton and Queen Street. I cannot and I will not say whether or not the inpatient population can be adequately taken out of a hospital bed and dumped in the community. I can't say that.

**Mr. Duktzta:** That's very cautious of you. In effect you accept that the closure of Lakeshore doesn't really add that much to the creation of new impetus to the community psychiatric movement, if we're not dealing with the inpatient in the hospital.

**Mr. Richardson:** I don't think you can make that comparison, necessarily. It was my understanding—

**Mr. Duktzta:** Will you accept that some people have to be institutionalized?

**Mr. Richardson:** Yes, I said that earlier.

**Mr. Duktzta:** If you accept that, then let me just move to where they should be institutionalized and what kind of a service. What do you think is an ideal way of institutionalizing this type of individual who is now in Lakeshore?

**Mr. Richardson:** Placing them in the most humane, supportive and home-like environment with the best treatment available.

**Mr. Duktzta:** Supportive, home-like—could you elaborate on that a bit?

**Mr. Richardson:** Not very well.

**Mr. Duktzta:** I was hoping that as a theoretician you could elaborate on this.

**Mr. Richardson:** I can only repeat about the published reactions and responses to the en-



vironment at Queen Street being modern, being homelike, adequate staffing, and so on. I can say that the Queen Street facility, as compared to the existing Whitby facility, for example, is very different.

**Mr. Duktzta:** Are you also aware of the joint commission report, which is at least 20 years old, or almost any other report since in the psychiatric movement, on community psychiatry, which suggests that there is an optimum size for a large institution? Are you aware how large those institutions should be to deal with the chronic patient?

**Mr. Richardson:** My understanding of the last figures is anywhere from 200 to 400.

**Mr. Duktzta:** Yes. But you are also, of course, aware that by coalescing two hospitals into one we may be creating an institution of 800 beds within five years.

**Mr. Richardson:** I am not aware of the total, accurate inpatient population at Queen Street and I would not be aware, following the consolidation and incorporation of other patients, what sort of—

**Mr. Duktzta:** Well, accept from me that we are planning on something like 700 beds within 10 years; according to the McKinsey demographic projections it may have to be as many as 800 for that very group which you say, and I agree, has to be, in fact, institutionalized.

**Mr. Richardson:** Yes.

**Mr. Duktzta:** So that is 800. Would you agree that this, in some sense, contradicts the theory that has been developed by various mental health associations and by the most forward-looking people in psychiatry that no institution should house more than 150 to 250 people?

**Mr. Richardson:** Clearly, I think your point is well taken and the implications of the closure of Lakeshore with regard to the inpatient population will create a much larger institutional base at Queen Street Mental Health Centre. Yes.

**Mr. Duktzta:** I just want to express some surprise that this, in effect, has not been taken into account by your organization and yourself. When your people were so enthusiastically supporting the whole concept of community psychiatry they were not aware that there was no new provision made for a community-based psychiatric service which would take three to five years, in your own words, to create; nor was there any movement, in effect, to deinstitutionalize an individual. They were going to combine two hospitals into one large institution. It is not mentioned here. All you see is, in fact, a

sort of easy acceptance that this is all for the best in the best of all possible worlds.

**Mr. Richardson:** Unfortunately, that is not true in any way. My comments were attempting to relate to that resolution of the board of directors, which specifically is restricted to the outpatient population and not to the totality of a larger institution, et cetera. We were very, very concerned—

**Mr. McClellan:** You supported the closing of the hospital.

**Mr. Richardson:** —with regard to the outpatient and the community alternatives. We were very concerned, obviously, that the outpatient group does have an adequate alternative to the hospital.

**Mr. McClellan:** You are ignoring the inpatients.

**Mr. Richardson:** It doesn't say that we have ignored the inpatients.

**Mr. Ramsay:** Mr. Chairman, I think the witness is being badgered. I am sitting here getting my blood pressure up.

**Mr. Duktzta:** Take a pill then, and don't bother.

**Mr. Ramsay:** Well, I think you have had the platform for a lengthy period of time.

**Mr. Duktzta:** No, I have one or two more questions, and does Mr. Ramsay now want to come in or not? It is true, I took longer.

**Mr. Chairman:** Yes, I think that we do have to watch the time somewhat, Mr. Duktzta.

**Mr. Duktzta:** I just want to ask one last question. Why has the association in their preoccupation with outpatient services not taken into account the inpatient population and the fact that the coalescing of two hospitals will produce a large hospital?

**Mr. Richardson:** I cannot reflect a policy of the organization on that question, Dr. Duktzta. I can only personally respond by saying that it was the opinion of our board and our advisers that the Queen Street Mental Health Centre could accommodate adequately an increase of an inpatient population group—not to our complete satisfaction, or to that of individuals, certainly, but that is as much as we can do at the moment.

**Mr. Duktzta:** One last comment: I am very shocked that the Canadian Mental Health Association, Ontario Division, is supporting to such a degree the coalescing and the creation of one very large institution sized for 800 beds. I find it unbelievable.

**Mr. Ramsay:** Mr. Chairman, I would like to make a comment or two, if I may, before

I question Mr. Richardson, and my questions will be brief.

I was asked by Mr. Lawlor—and it was a good question and he asked it in kindness before this meeting—if I was being objective in my approach to this—I think he was referring to the fact that I am a relatively new member of only a couple of months' standing. I said I was trying to be.

[3:30]

I've listened this afternoon to the questions presented to Mr. Richardson, whose views are obviously not completely in line with the NDP caucus, and I wonder, truly, if they are being objective in their approach to the witnesses. They've attempted, I find, to question the credibility or the testimony of this witness.

Mr. Johnston and Mr. Lawlor made very eloquent statements—I wish I had the ability to speak as they do—but those were statements and not questions to the witness. There were interjections from the NDP caucus without reference to the chair or permission from the chair. Is this the way that committees are run in this Legislature? If it is, I find that questionable.

Everything I said today is with respect to these gentlemen, whose motives I think are of the highest order. They're trying to get to the bottom of this matter with the Lakeshore Psychiatric Hospital, but I'm not sure that they're being completely objective in trying to do so. I think you've been unfair to Mr. Richardson today—I've never met this man before and I have no association with him or anything else. Now that I've said that and got it off my chest, I'll get back to the—

**Mr. R. F. Johnston:** I suppose all members are entitled to statements, Mr. Ramsay, and yours is quite appropriate under the circumstances.

**Mr. Duksza:** I was trying to determine whether the expert knew what he was talking about and to get to the essence of the recommendation that he brought here, which will have a direct bearing on the closing or otherwise of the Lakeshore Psychiatric Hospital.

**Mr. Kennedy:** That explains what you're attempting to do.

**Mr. Duksza:** Thank you, Mr. Kennedy, for accepting the apology.

**Mr. Chairman:** Mr. Ramsay feels everyone should go through the chair before any comments are made.

Continue, Mr. Ramsay.

**Mr. McClellan:** He'll learn.

**Mr. Ramsay:** Mr. Richardson, yesterday I listened and, during the previous day's testimony, I listened to the problems with the residences, particularly those in Parkdale. Those things disturb and worry me. My philosophy is basically what you stated, that we should keep people out of hospitals—I'm referring to chronic hospitals, as well as psychiatric hospitals—and I've been involved in the health care field for a great number of years. However, I think you have to have proper alternatives. I was terribly concerned and upset when I heard the descriptions of some of these group homes throughout Parkdale in particular.

Now, I'm asking you as a gentleman whose responsibilities include associations concerned with health care across the province, and not just Metro and Parkdale, if circumstances are the same across the province. Are we having that same problem in Sault Ste. Marie, Sudbury, North Bay and London, and so on, where these group homes are really just a depository for the patient—some place to put them away and out of sight?

**Mr. Richardson:** I think quite often the response from ratepayers' groups, and so on, is to a very, very unfortunate and deplorable situation. Certainly from my observation I can say that that represents for the most part the situation in Ontario.

However, any influx of clinical groups—if I can use that term, and I'm not an expert—with a handicap of one kind or another is going to create some consternation and fear. The association for the mentally retarded has experienced this. The Ontario Society for Crippled Children has experienced this. The Canadian National Institute for the Blind has experienced this. Certainly we have. We can only be working with ratepayers' groups and working with municipal bylaws and zoning procedures and so on which, in Toronto, has made some progress. But it does not represent the situation in Ontario.

**Mr. Ramsay:** It doesn't. In other words, there are group homes across the province that are properly run where the patients are looked after with compassion. They get proper outpatient treatment and consultation and so on.

**Mr. Richardson:** Of course.

**Mr. Ramsay:** The only other thing I wanted to ask you is if the philosophy of the association, as you expressed it, seems to be to keep people out of hospitals and so on. In this respect, has your association been ahead of the ministry? Have you been ahead of your time or is this a philosophy that has just



come about within your association in the last number of years?

**Mr. Richardson:** Let me say that our philosophy and policies are not always consistent with that of the ministry.

**Mr. Ramsay:** No, I didn't think they would be.

**Mr. Richardson:** Whether we're ahead or behind, I don't know. Not having any specific political interests and vested concerns, and so on, we feel more free to make presentations and recommendations and so on.

The policy of deinstitutionalization and community care and alternatives was, to my recollection, initiated in Ontario in 1972, 1973 and 1974, with a House vote which established the adult community mental health branch, I believe, the first real move toward community mental health resources in Ontario—at least, as far as the government of Ontario was concerned. And we supported that, very heavily.

**Mr. Ramsay:** Were you advocating this before that?

**Mr. Richardson:** Yes, sir. That's the point I want to make.

**Mr. Ramsay:** Thank you.

**Mr. Richardson:** Thank you, sir.

**Mr. McClellan:** I have to confess to being somewhat flabbergasted by the fact that your association has the resolution supporting the closure of Lakeshore Psychiatric, with provisos, eight days before it was closed.

We've had testimony from the administrator of Lakeshore Psychiatric Hospital before this committee and under questioning from Mr. Conway—the Liberal Party's Health critic—who asked on April 24 during the committee sitting "When and how, Mr. McMullen, did you personally hear of the government's intention to close Lakeshore?" Mr. McMullen: "January 22." Mr. Conway: "You were given no prior notice?" Mr. McMullen: "No."

Now, I simply don't understand how your association was in a position to receive a written report from you—and I assume to debate the report and to pass a comprehensive motion with respect to the closure of Lakeshore Psychiatric—before that decision had been announced.

You've alluded to an article in the newspaper, and I've tried to make a determination about that article in the newspaper, the best of our recollection is that there was a reference in one of Claire Hoy's columns to the possibility of a decision with respect to the closing of Lakeshore. It was very, very tentative. Very, very tentative.

**Mr. Richardson:** Any article in the newspaper, we have to research and find out whether it's tentative or not. All I can assure you is that there was no collusion between the CMHA and the Ministry of Health to pat each other on the back, saying, "Let's get rid of this thing for whatever reason." I will double-check the date on that minute and reassure you personally tomorrow as to the date of that board meeting, the date of the article, the newspaper, and the time.

**Mr. McClellan:** I'd be grateful for that. It is of enormous concern to me and I won't pursue it until I hear from you.

**Mr. Richardson:** I appreciate that. And I'll do that.

**Mr. McClellan:** The fact remains that if you knew about it before January 22 you are the only people in the province of Ontario who knew about it, outside of the Ministry of Health. And I say, know about it.

**Mr. Richardson:** Other than newspaper articles and official announcements, the discussions in and out of the hospital clearly do not indicate that. But that's very, very subjective data and I place no reliability on that.

**Mr. McClellan:** All I can go on is the evidence that's been presented before this parliamentary committee and we to rely on that. I would be grateful if you would double-check that. A lot of ground has been covered at length. Because of the significance of your position as an organization with respect to this issue, you are the major legitimizers of the decision to close the Lakeshore Psychiatric Hospital in the voluntary sector. You are the one voice that is speaking out in support, with provisos, but in support of the closure of Lakeshore. That's why we are giving you a hard time. I hope you won't take it personally.

**Mr. Richardson:** You should—I mean you should be giving me a hard time.

**Mr. McClellan:** Yes, because of the role that the CMHA is playing in this episode. Now, I want to go back to the question of the provisos in your resolution. You support the closure of Lakeshore Psychiatric Hospital, provided that at the time of such a closing a suitable range of alternatives are in place and working. Now, let me backtrack.

Are you familiar with the process the province of Ontario went through in establishing community living facilities for the mentally retarded? Has your organization participated at all in that very creative and positive exercise?

**Mr. Richardson:** Not to my knowledge.



**Mr. McClellan:** The process, if I may, started in 1971 with the Williston report, which was then studied for three years. That was followed by the production of a green paper on normal community living facilities for the mentally retarded which was issued in 1974. It was adopted after a year of discussion by the government as government policy. A division of Community and Social Services was established and huge amounts of new money were put into the creation of community living arrangements, services, and facilities for the mentally retarded—amounts of money well in excess of \$50 million a year, large amounts of money. That system still is not in place.

Despite nine years of planning and a serious commitment on the part of the government to do it and fund it, after nine years we don't have group home facilities for mentally retarded people in Metropolitan Toronto. There's a thing still on the drawing boards for a facility in Etobicoke, but the facility for Toronto is still only a regional centre in Orillia. That's my only experience with a serious program of alternatives to institutional care.

If you want us to support the position that you're taking, you have to be able to convince us that the alternatives can be in place, and the question is back to you again. Do you have any grounds at all to believe there will be an alternative care system in place when Lakeshore closes on, for all practical purposes, on May 23?

**Mr. Richardson:** Yes. I'm sure that last Monday afternoon, and correct me if I'm wrong, at two o'clock Audrey McLaughlin made a presentation to this committee. I wasn't here for that presentation. However, I did sit in on one meeting of the outpatient planning committee between the hospital, other community groups, and the ministry, and have seen drafts of plans, one, in particular, by Mental Health Etobicoke, which is a council of CMHA, Metro Toronto. This outlined in a fair amount of detail a plan to incorporate outpatients into approximately eight or nine conglomerate areas, I believe they're referred to. That was but one plan that I saw in detail. I have not seen the others, so I can't comment on the detail personally.

However, through Miss McLaughlin and other people, in the North York group in particular, I am aware that they too have presented very comprehensive plans to Mr. Jappy and to Dr. Lynes, and are pushing very hard for them to incorporate these plans into their existing programs at the moment.

[3:45]

**Mr. McClellan:** Let me ask you. Did these plans that you've seen or discussed include the provision of non-institutional housing alternatives for mental health patients?

**Mr. Richardson:** My understanding is that proposals have included alternative housing programs, yes.

**Mr. McClellan:** In Etobicoke?

**Mr. Richardson:** I'm quite sure in Etobicoke, because a large population of individuals obviously resides there. The monitoring of those plans have been incorporated and assumed in the responsibility for such of the branch in Toronto and its four, five, six councils, specifically Etobicoke, and their branches in Peel and Hamilton.

**Mr. McClellan:** How were these homes going to be built in Etobicoke when Etobicoke has managed to succeed in zoning these kinds of facilities out of the borough?

**Mr. Richardson:** I presume that consideration was taken into account and will be dealt with through the public education efforts of the branch in Etobicoke. I am not aware at this point of the Etobicoke council identifying—and again I may be wrong—X number of outpatients coming from Lakeshore who will be without housing accommodations as a direct result of the closure of Lakeshore. I am not aware of that. I have asked this question repeatedly. I have not been given any data.

**Mr. McClellan:** You're speaking then to the adequacy of existing housing arrangements?

**Mr. Richardson:** Partially, and additional housing arrangements.

**Mr. McClellan:** Yes, but your report speaks to that question and testimony before the committee speaks to that question, that the housing arrangements are deplorable. I'm trying to understand what your provisos mean. I'm trying to get an understanding from you of what your conditions are with respect to your support for Lakeshore. You say, "We support it, providing that a suitable range of alternatives are in place," but I don't understand what the suitable range of alternatives are.

**Mr. Richardson:** We presume and we assume that there has to be some trust between the levels of our association and the provincial board of directors trusts Mental Health Metro, and its council, to identify specifically by numbers of people and their exact requirements, along with ministry people, other planning agencies, and service agencies for that matter, precisely what kinds of housing requirements, or rehabilitation re-

quirements are needed. We can only assume on the basis of that delegation, therefore, that that need will be met.

**Mr. McClellan:** So that you're trusting in a kind of a process to take place at the community level around the identification of the suitable range of alternatives.

**Mr. Richardson:** We believe it must take place at the community level, yes.

**Mr. McClellan:** By when, by what time? At what point are you going to hold yourselves accountable for the resolution you've passed?

**Mr. Richardson:** The extent to which those alternatives are in place have been mutually accepted by Mental Health Metro. That board of directors I also understand, as Miss McLaughlin had reported, have been supporting that resolution of the board of directors of Mental Health Ontario. We have stood very firm that if at the time of the ultimate closure of the facility the alternatives are not in place, CMHA will obviously have to have a lot to do and a lot to say. It will be a matter that our trust in the community's ability to come up with a comprehensive plan was simply not strong enough.

**Mr. McClellan:** Are you aware in any detail of the difficulties that the existing array of outpatient services at Lakeshore Psychiatric Hospital are encountering?

**Mr. Richardson:** I can't answer that.

**Mr. McClellan:** You're not aware of the difficulties within the behaviour therapy unit, for example?

**Mr. Richardson:** I understand through the one meeting I attended at the behaviour therapy units that individuals were looking for new quarters to house that particular unit.

**Mr. McClellan:** But the difficulty is that four of their six staff have been laid off.

**Mr. Richardson:** I'm sorry. I'm not aware of that.

**Mr. McClellan:** Right.

**Mr. Richardson:** No, I'm not.

**Mr. McClellan:** Right. And they're in the process now of entering their program here without sufficient staff to train volunteers, and it's a volunteer program, as you know. Are you aware of the difficulty the alcohol unit is confronted with in not having accommodation, not knowing where it will be located, what the state of the inpatient service will be, or whether it will have an inpatient service?

**Mr. Richardson:** I understand they were to submit a plan to the outpatient committee. I appreciate that information about the staff

of the behavioural unit. I wasn't aware of that.

**Mr. McClellan:** When the ministry built Queen Street, the new four-tower facility at 999 Queen Street, there was a certain amount of energy expended by a number of social workers, mental health professionals, other people, trying to persuade the government not to build the fourth tower. Do you recall that?

**Mr. Richardson:** No, I don't.

**Mr. McClellan:** Were you with the Canadian Mental Health Association at that time? This was in 1973, 1974.

**Mr. Richardson:** I joined the group in 1974—at the end of 1973.

**Mr. McClellan:** You haven't, as an association, looked at the question of Queen Street itself, at what Dr. Duksza calls "the total institution," or have you?

**Mr. Richardson:** The provincial division has not specifically investigated Queen Street, no. Our branch in Toronto has been very much involved with the programs at Queen Street Mental Health Centre, as is evidenced in our report.

**Mr. McClellan:** But in the course of your work over the last year and a half, two years, or prior to that, you haven't looked seriously at the size of the Queen Street facility, and the impact of such a huge institution on the mental health care system in the Metropolitan Toronto region?

**Mr. Richardson:** Again, the division office has not done any case-study analysis of the impact of the size of the institution to the patient population. I have had conversations with some of the administrative staff and the professional staff, but the conversations have not specifically dealt with that.

**Mr. McClellan:** Is your association aware of the detailed plans for accommodating the Lakeshore inpatient population at Queen Street?

**Mr. Richardson:** We were not given a detailed plan. I don't understand that anyone was given a detailed plan.

**Mr. McClellan:** No, but subsequent to the announcement.

**Mr. Richardson:** No.

**Mr. McClellan:** There's been a lot of planning. For example, the ministry intends to increase the size of the psychogeriatric wards at Queen Street from 34 patients per ward to 50 patients per ward. We've heard testimony from people that work at Queen Street, and I don't think I'm exaggerating at all, who are distressed at that kind of a plan. One of the medical witnesses before the committee testi-



fied that would mean, quite simply, elderly people would be lying in their own excrement in that ward. This information isn't anything that has come to the attention of the Canadian Mental Health Association?

**Mr. Richardson:** Not to the division office with regard to the size of the wards, the nature of the patients' circumstances, and so on. I can assure you if it was, it would have been dealt with.

**Mr. McClellan:** Perhaps in conclusion I might just suggest to you, Mr. Richardson, that you obtain a transcript of the evidence before this committee and read it.

**Mr. Richardson:** I would appreciate that.

**Mr. McClellan:** I would be interested to hear from you on a personal level, having read the evidence, what your views are then. And I mean that quite sincerely. As a social worker, I am convinced we are playing Russian roulette in this exercise and as you, yourself, said the blood of the mentally ill will be on our hands.

**Mr. Lawlor:** I'll give a partial explanation of why we've placed considerable emphasis on this questioning. There was a meeting at Lakeshore, a community meeting with 250 or 300 people present, at one of the local churches, early in February after this announcement was made. One of the representatives from Metropolitan Toronto Mental Health Association appeared, and he didn't say what you're saying today. He simply said, "We're in favour—and I'm given authorization to say that we're in favour—of closing the hospital."

He was the only person who appeared on that occasion who made a statement of that particular kind. There weren't any ifs, ands, and buts. None of your stipulations or convictions. What you're saying to us today—and I appreciate it—is quite a different bird to what was said, apparently representing your position, on that particular occasion.

That's part of the reason why my back was up if you want to know. There was this carte blanche information from the ministry. As I read your resolution, it's radically different from what was originally presented to us. That wasn't well received, as you can imagine.

Did you have any contact with the McKinsey people during the course of their deliberations subsequent to your report?

**Mr. Richardson:** No.

**Mr. Lawlor:** Are you aware they had the benefit of your report in the preparation of their own report?

**Mr. Richardson:** Sorry, "The benefit of my report", which report?

**Mr. Lawlor:** The benefit of the Canadian Mental Health Association report to which I was referring earlier.

**Mr. Richardson:** The Mental Health Metro branch in Toronto, the blue report? They did have access to that, yes.

**Mr. Lawlor:** I'm going to ask you a very difficult question. Would you be prepared to give some consideration to altering your position a little bit? I think you've got the cart before the horse, you see. Would you be prepared to advise the ministry that until your conditions are met, and the facilities in place, that your association would be opposed to the closing of the Lakeshore?

**Mr. Richardson:** A very good point; thank you for asking it. We have formally and informally communicated with ministry officials and particularly with Mr. Jappy to press for the formalization and the criteria for the approval or rejection of the plans that community groups are proposing relative to the inpatient and outpatient populations at Lakeshore. It's my understanding, and I'm sorry I don't have up-to-date information as to the approval or the rejection of the various proposals—they will be made public to the community groups, both on the basis of those approved and those not approved. The CMHA, both in Metropolitan Toronto and in Ontario, will have access to those decisions and a chance to respond.

**Mr. Lawlor:** Through your organization, perhaps, probably that's the best way to get it, we would be very much pleased to receive whatever these responses might be.

**Mr. Richardson:** I already have had one invitation, and I look forward to others.

**Mr. Chairman:** Thank you very much, Mr. Richardson. Obviously there are differences of opinion between the views expressed by your association and those held by some of the members of the committee. For that reason the questioning has been a little more vigorous than may otherwise have been the case. I hope you haven't felt harassed or badgered, because I'm sure that wasn't the intent.

**Mr. Richardson:** Not at all. It's an extremely serious and important process and we appreciate the comments. I'm perfectly prepared to respond to the questions and communicate with the members formally and informally.

**Mr. Chairman:** Dr. Appleford is the Peel County Health Unit medical director, I believe.

**Dr. Appleford:** That's right, sir.



**Mr. Chairman:** Do you have a statement? [4:00]

**Dr. Appleford:** Just a short statement, Mr. Chairman, to the effect that my interest and the interest of our whole health unit, for that matter, is in the prevention and the amelioration of diseases that have developed. We work entirely in the community, and as such would be a community advocate for care of all people, let alone mental health people within the community. I personally have watched the disappearance of custodial beds in the province for the past 10 years.

It's been a very forward step, and rather dramatic, and since it's been successful, I think it should be proceeded with: I'm speaking of custodial beds; I'm sure Dr. Duksza and I will have conversations about that.

As you know, our public health nursing division is really an outpatient itself without any central core. We do all our visiting in the homes, or speaking to groups, within the area, and we have always been aware of our role of followup on referrals by physicians and psychiatrists to people in the home. We act on their orders and directions. We feel it's a very valuable service because many of these people only require monitoring, in which case it's a visit, a checkup to see how things are going, and a report back to the referral agency or, in our case, the physician, as to what is going on and any corrections he would like to make.

Our psychiatric referrals have increased: in 1977 we received a total of 32; in 1978, 118; and in the first three months of this year, 22. These are all from psychiatric establishments.

In our case, it's largely from Mississauga, Peel Memorial, and some outside hospitals. We have not received many referrals from Lakeshore, presumably because they've been carrying on their own outpatient facility, which didn't require our services to the Peel residents from their site. These psychiatric referrals have accumulated over the years from 3,800 in 1976 to 6,300 in 1978, with 1,400 in the first two months of this year. So you can see we're well on the way to providing this service as a backup to the psychiatric facilities in our region, and are prepared to assume our role, if we're called upon, by the Lakeshore outpatient facility. But I'm presuming, if the minister's statements are correct, that that facility will carry on in other ways.

We're also involved, though, with Lakeshore, in group mental health. As you're aware—I'm sure it's been explained to the committee—there is an organization called Peel Aftercare Resources. This was a pilot project set up by Lakeshore and the Mental

Health branch in Peel and is this year being administered by Mississauga Hospital. But in 1977 our nurses counselled 355 clients, in 1978, 709, and so far this year 45. Counselling is done in groups; three, four, five or six patients are accumulated at Peel Aftercare Resources. The ministry has approved the formation of a similar organization in what we call north Peel, or the Brampton area, and we will be carrying on that organization as soon as it's established, which is expected almost any day.

I don't know if you've heard from any public health official, but I can speak for most of my contemporaries that we, in public health, feel that we're community nurses and community organized. This is where we feel the followup of the non-custodial so-called mental patient should take place. That's all I have to say in the form of a statement.

**Mr. R. F. Johnston:** Mr. Chairman, I'd like to start out with a statement, now.

**Mr. Chairman:** A very brief statement.

**Mr. R. F. Johnston:** I think I took that last witness' questioning very personally—subjectively rather than objectively—and I admit to that. I don't think you're going to run into the same problem from me at all.

Public health staff traditionally take up a large amount of slack in the community, and retrieve a lot of people who are missed in the system as well, because referrals come to public health from so many different kinds of sources. You've mentioned a few of the institutional sources.

My experience has been—and I wonder if you can tell me what the experience is in Peel—that there are a large number of patients who come to the awareness of public health nurses through other sources, but these people are ex-psychiatric patients. They do not come through the institution in direct after-care. Can you tell me a bit about that in Peel? Do you have documentation for them?

**Dr. Appleford:** No, I haven't, not for those not referred. We, in many ways, try to discourage diagnosis by public health nurses, if you know what I mean.

**Mr. R. F. Johnston:** Right.

**Dr. Appleford:** Certainly our people are trained to the extent that if they are aware of a person of this nature in the community who isn't being cared for, they will certainly encourage that assessment by someone so that the referral can be made properly.

**Mr. R. F. Johnston:** I guess it was in Durham region, which I was familiar with and which in some ways is like Peel, a large number—it wasn't that the nurses were necessarily making psychiatric assessments, but often in

meeting a new patient who would be referred by a GP, usually they would find the person would volunteer, "I've been in Whitby a number of times," or whatever, I guess what I'm leading to is this. I presume the same sort of situation takes place in Peel and I'm looking for the fact that there are a lot of people who are not picked up by an after-care component directly from a hospital, but who are out there in the community, known by their GP, they drift in and out of the other service sectors and their needs are never adequately met; that group is never given the proper kind of resource, and it often falls upon public health nurses to do it.

**Dr. Appleford:** You're quite right.

**Mr. R. F. Johnston:** I wonder if you could tell us a bit about your public health staff case-load. My knowledge is that most public health nurses are pretty heavily taxed.

**Dr. Appleford:** Yes, I suppose, we have been in that situation in Peel, though it isn't particularly true of the other public health units throughout the province. It's a very difficult task, and we have to set out priorities on what a nurse's case-load can be. This is done mainly with consultation with the supervisors, and suggesting that certain people should be discharged, so the case-load doesn't grow too greatly.

We have discussed over the past year, on our psychiatric case-load, that we must find a better way of an assessment, because some of the nurses feel that the patient has got along so well that he can what we call "be discharged" from her case-load, unless some new evidence comes to light in some other way. There is a tendency for the case-loads to go that way.

But we have, as I said at the outset, considered mental health as a priority item, and no one is discharged from that group without very careful consideration.

**Mr. R. F. Johnston:** But it has been noted as a concern by public health nurses.

**Dr. Appleford:** The case-loads.

**Mr. R. F. Johnston:** Right. I'm interested to know what the formal administrative chain connection is between Lakeshore Psychiatric Hospital and your public health unit, in terms of discharged patients into the community. How does that work?

**Dr. Appleford:** I can't answer for Lakeshore because, as I say, our referrals have been quite a few over the years. But our connection with Lakeshore has been excellent. Our nurses have been there for their inservice education—mainly to keep up with what's going on—and our real liaison is with the two psychiatric units in the general

hospitals. We have liaison nurses in each hospital. The discharge team on the psychiatric area include our nurse in the discharge procedure. The question is can the public health nurse be of assistance in this case, then, if so the case is taken on through that consultation process. So she is involved in all discharges from the psychiatric area.

**Mr. R. F. Johnston:** So Lakeshore is primarily a resource and training component to your public health staff at this time.

**Dr. Appleford:** Yes.

**Mr. Kennedy:** Dr. Appleford, the Peel health unit has the whole broad range of health services. What portion of your time, staff, or budget is involved in mental health in the overall function of the Peel health unit?

**Dr. Appleford:** I would say that if you consider all aspects of mental health it's about 30 per cent. There are mental health aspects in almost 30 per cent of the cases although that may not be directly as with a patient who has been diagnosed as a psychoneurotic.

**Mr. Kennedy:** Would this be roughly comparable to other health units across the province, do you suppose? Or does it vary somewhat?

**Dr. Appleford:** It varies from unit to unit. I think the variation is mainly whether it's urban or rural.

**Mr. Kennedy:** Perhaps the more tranquil areas of the province.

**Dr. Appleford:** I think we feel the pressure, right.

**Mr. Kennedy:** Do you support this move—if I understood your opening remarks? What is your view on moving toward more community-based services and, at the same time, the relationship with an inpatient facility with all the auxiliary accessory services provided?

**Dr. Appleford:** Well, I'm sure you've heard, in your testimony prior to today, from a great many people far better equipped to answer Mr. Kennedy's question than I am. However, I think you can tell by my hair that I've been associated with the practice of medicine for a great many years, and I have been through the era from the complete custodial period to the advent of private psychiatry, which followed, in the main, the last war. I've seen the developments in that and how well the private psychiatrists were able to develop their units in general hospitals. But, getting around to your question on the units in general hospitals, the component of custodial care there is vastly different than it tradi-



tionally has been in psychiatric or Ontario hospitals, or whatever the name was. It's rather difficult to compare a unit in a general hospital with a unit in a psychiatric hospital directly, because they vary tremendously. As you well know, in Metro Toronto, they vary from circumstance to circumstance, depending on their very stress, whether it's research and that sort of thing.

I think we'll always be faced with a degree of custodial care, and I'm no expert on how that care may best be provided. You've heard the previous speaker—it should be humane and it should be comfortable and all the rest. That care will always be necessary. I think, from the prevention side and the reduction of stress, if we are able to deal with people in the communities without designating them as patients of a mental hospital or a psychiatric unit, that is the goal to which we should aspire.

[4:15]

**Mr. Kennedy:** How closely are you related to the Lakeshore—and Queen Street, for that matter? What is your involvement? What I'm trying to get at is that we're faced with this problem of the closure and I'm wondering what impact this will have on the services being provided to Peel, which presumably will relate to other communities, as well.

**Dr. Appleford:** I can't answer that question directly, other than to say that it will depend on the final working out of the outpatients' facilities at Lakeshore. I understand they're still to be in place, but whether all these patients will eventually relate to Queen Street, Mississauga, or Peel Memorial, if that's where their address is, I can't say. I would presume a great many of them may.

**Mr. Kennedy:** Well, the minister's made the commitment that not only will all the existing and outpatients services be maintained but they will be enriched by something like \$1.3 million. Now, knowing this, do you think that outpatient services or mental health services will suffer if this closure takes place? I think this is one of the basic things that we must wrestle with.

**Dr. Appleford:** Well, my personal opinion is that certain aspects of them may. You cannot be sure how a unit has been set up. Take for instance, a rehab unit. It may take a month or two to adjust that to some other basis. In general, outpatient services are part of the system where the psychiatrist sets up a program for the individual which, to my mind, can be carried out even through the public health nurse.

As I say, we're not receiving any referrals from Lakeshore at the present time.

**Mr. Kennedy:** I just have one other question, Mr. Chairman. You did give us quite a few figures that boggled our minds. I can reread them, there's no problem that way. You mentioned two facilities in Peel. In this respect, are you referring to the existing hospitals that have a branch for mental health services or some other facilities?

**Dr. Appleford:** Mr. Chairman, I think Mr. Kennedy is referring to my mention to PAR, which is Peel Aftercare Resources.

**Mr. Kennedy:** I recall you mentioning that. But I think, prior to that, you mentioned that there were two facilities.

**Dr. Appleford:** Those are the psychiatric facilities in Mississauga and Peel Memorial Hospitals.

**Mr. Kennedy:** How adequate are they?

**Dr. Appleford:** With the expansion of the population in Peel, there's some query of their adequacy, but I can't really answer that directly. I think that the psychiatrists in those units will simply have to work through the situation as it arises.

**Mr. Kennedy:** Do you feel basically that local general hospitals can be expanded in providing service to mental patients?

**Dr. Appleford:** Oh, yes. I feel that our new hospital that's on stream now, may have quite a large component—75 or 80 beds—centralizing some of the psychiatric facilities in its planning. There is enlargement planned both at Mississauga and Peel in present expansions.

**Mr. Kennedy:** In their present planning, yes.

Thank you very much, Mr. Chairman.

**Mr. Chairman:** Mr. Leluk, and then Mr. Lawlor.

**Mr. Leluk:** Thank you, Mr. Chairman. I'd like to ask Dr. Appleford a question which our previous witness, Mr. Richardson, the executive director of the Ontario Mental Health Association, couldn't answer. Do you, in your medical opinion, feel that there is an overlap in services between the Lakeshore Psychiatric Hospital and the general hospitals' psychiatric units in the Mississauga, Etobicoke and the catchment areas? Do you feel there's an overlap in services? If so, what would these be, and why?

**Dr. Appleford:** The overlap, I feel, might be in the outpatient end of it. I don't see any actual overlap within bed-patients because I am presuming that because of their outpatient load that Lakeshore Psychiatric has acquired a case-load of psychoneurotic patients and other anxiety states, and so forth,



which wouldn't necessarily require custodial care. In other words, their case-loads are probably more similar to a psychiatric unit in a general hospital than to, mainly, the custodial care hospitals.

**Mr. Leluk:** As a physician do you have any views on that role, you feel, that the general hospitals' psychiatric units should play in providing mental health services to the community?

**Dr. Appleford:** I think they should provide all of them except custodial care, which is long-term chronic custodial care. I don't know how we're going to answer that problem.

**Mr. Leluk:** It has been said at this committee, particularly by the members of the New Democratic Party, that they are concerned over the future size of the Queen Street Mental Health Centre. Do you as a physician feel that the size would have some negative affect on the quality of care that might be provided to the patients in that hospital?

**Dr. Appleford:** Sir, I can't answer that question. I have not been involved in psychiatric hospital planning as such. I can only say that during the war I administered a hospital of 800 patients of which 350 were psychiatric patients, and we got along.

**Mr. Leluk:** There's also been some concern expressed here by some of our witnesses regarding the accessibility of the Queen Street Mental Health Centre, and that general hospitals are reluctant to deal with Queen Street. Have you any views on that, or have you in the medical profession heard any—

**Dr. Appleford:** No, I haven't. No, that would have to come from the psychiatrists who are referring cases to those two hospitals.

**Mr. Leluk:** The Minister of Health, when he appeared before the committee earlier, made a statement that the inpatient population in our psychiatric hospitals in the province has been declining over the last 10 years. Do you feel that this is something that might continue, or do you see a levelling-off of this decline in the inpatient population in our psychiatric hospitals, or do you have any views on that?

**Dr. Appleford:** I see it continuing, though I have no statistics to back that up. It would surprise me. I don't know of anything on the horizon that says it shouldn't continue. We talk of the bottom line of how low we're going to get. I think that's a defeatist attitude. I think that from the preventive side we're going to continue. In my experience in running clinics and that sort of thing, in connection with London Psychiatric, we got a

tremendous number of people out of hospital and looked after them, I think, fairly satisfactorily. Unless some change in our culture occurs I can't see that changing, but I am no expert on number of beds per population per whatever. That would have to come from somewhere else. I think any successful program will probably continue unless something unusual comes along to prevent it.

I'm interjecting here on tuberculosis but, Mr. Chairman, I hope you'll excuse me. When I was in practice the province was dotted with sanitariums. It's a different problem, I realize, but there were people who said we would never get rid of sanitariums. We have. Those patients are taken care of very well now in general hospitals. Mind you, the case rate is low, but from the prevention standpoint, I refuse to be a defeatist; I'm an optimist in that regard.

**Mr. Leluk:** On that note, could I ask you this question, Dr. Appleford? Do you support the closure of this hospital, the Lakeshore Psychiatric Hospital?

**Dr. Appleford:** I support the closing of custodial beds where they can be closed. I haven't any expert opinion about the situation at Lakeshore. I haven't studied it to that degree, but in principle I support the closing of custodial beds where they can be closed.

**Mr. Leluk:** I have no further questions, Mr. Chairman. Thank you.

**Mr. Chairman:** Mr. Lawlor?

**Mr. Lawlor:** Doctor, I have before me a brief the Social Planning Council of Peel submitted to this committee. Let me read from it and then you may comment on it. On page two it says: "Service gaps in Peel: The closure of the Lakeshore poses some immediate problems for the Peel community. There's no crisis intervention or emergency psychiatric facility in Mississauga. The Mississauga Hospital does not have in place the services that a psychiatric facility in a general hospital should have. Without the Lakeshore Psychiatric Hospital, Peel has no day hospital, no hostel, no clinics for adolescents or alcoholics, and no prevention programs."

**Dr. Appleford:** I can't agree with those statements.

**Mr. Lawlor:** Do you care to comment further, and in more detail perhaps, on the social planning council submission?

**Dr. Appleford:** We have two psychiatric units in place in both hospitals. We have had the backup of Lakeshore, and I presume we'll have the backup of Queen Street Crisis Intervention Centre, and plans are under way at both hospitals for expansions of their psychiatric units.

**Mr. Lawlor:** When do you anticipate they'll come on stream?

**Dr. Appleford:** Those expansions are past the planning stage. When they're actually projected to be on stream, I can't say.

**Mr. Lawlor:** Doctor, it goes on and says on page three: "Financial commitment of the province: The council is concerned that the province appears to be reducing its spending for mental health services in our community. The Lakeshore closing purports to save \$2.6 million in 1979-80. Only half this \$2.6 million is the province willing to redirect to community mental health services. This means that in effect the catchment area will experience a net reduction of \$1.3 million in provincial spending. Based on population alone, Peel will experience a net reduction of \$430,000 in one year alone. Peel, a region characterized by recent rapid population growth and a dearth of community mental health services, should not be the victim of a provincial strategy to cut over all spending in mental health programs." Have you any comment on that?

**Dr. Appleford:** Yes, I'm not aware of those figures. I am quite well aware the district health council has a committee. One of our senior public health nurses is on it and, as I understand it, the purpose of the district health council committee is to simply lay before the minister what is necessary. I can't quote the figures. Those plans haven't yet reached the Ministry of Health.

**Mr. Lawlor:** Let us trust the great Lord in the sky is beneficent. Doctor, correct me if I'm wrong, as I was trying to take down figures while you were speaking. You spoke, as I understand, of referrals in the number of 3,876. There were 6,300 in 1978. Is this correct?

**Dr. Appleford:** Yes.

**Mr. Lawlor:** That's a monumental increase.

**Dr. Appleford:** It is.

**Mr. Lawlor:** Have you any estimate or projection as to the impact on those figures by the closing of Lakeshore?

**Dr. Appleford:** I think I mentioned before, sir—you may have been out of the room—but we have no way of assessing our referrals from Lakeshore. We had two in 1978 and we've had none in 1979 yet, so we have not had referrals from Lakeshore.

**Mr. Lawlor:** Can't say?

**Dr. Appleford:** No. I think they preferred—well, I shouldn't comment as to why.

**Mr. Lawlor:** That's fair. You spoke of a followup program in your area and the pro-

vision of group homes. How many group homes are there presently in existence?

[4:30]

**Dr. Appleford:** No, I didn't mention group homes, sir. I spoke of Peel Aftercare Resources. This is not a group home.

**Mr. Lawlor:** Oh. I want to concentrate on group homes.

**Dr. Appleford:** It's a day-care centre.

**Mr. Lawlor:** How many would be available right now?

**Dr. Appleford:** I can't answer that, in Peel. We, as the health unit, have put forward a proposition to provide a halfway house for Peel Memorial Hospital. That is still before the ministry. As to mental health in Peel, I'd need to inquire from the mental health branch. It's my impression that we don't have many, as such.

**Mr. Lawlor:** I am content.

**Mr. Duksza:** To answer the question, there are none.

**Mr. Chairman:** Mr. Johnston, you have one short question?

**Mr. R. F. Johnston:** There are just one or two things I want to have clarified. One was that you said you are in favour of getting rid of custodial beds. I think it should be made clear that what we are talking about is moving beds from Lakeshore to Queen Street. We aren't talking about reducing the number of beds that would be occupied, therefore the advantage in closing Lakeshore is not one of actually losing custodial beds, as I understand it. Do you understand?

**Dr. Appleford:** Yes, I understand what you mean.

**Mr. R. F. Johnston:** The other was that you were asked about overlap between the general hospital psychiatric units and Lakeshore. Again, not having very much connection with Lakeshore in terms of referrals and that sort of thing, you said that you thought there was or there might be an overlap in the fact that Lakeshore might be looking after psychoneurotics as outpatients. On what do you base that, rather than primarily psychotics?

**Dr. Appleford:** The number of psychotic patients in the community is not very great; that is, the people who are a danger to themselves and to others are primarily custodial. Psychoneurosis is another disease entirely of which the patient has all his capabilities, it's just that he is not, shall we say, able to use them properly; he is in an anxiety state, or is depressed, or is unable to work, or he could be a recovered alcoholic,



say, who has problems as well with his functioning within the society. But you can't call him psychotic.

**Mr. R. F. Johnston:** You are saying that there are psychoneurotic patients, outpatients, being dealt with by Lakeshore who could be dealt with by general hospitals in Peel; is that essentially what you are saying when you are talking about overlap?

**Dr. Appleford:** That's my impression.

**Mr. R. F. Johnston:** All right. Why is that? Why do you have that impression?

**Dr. Appleford:** Because of the size of the outpatient facility. I just can't believe that that number of outpatients would be psychotic.

**Mr. R. F. Johnston:** But it's not from actual case knowledge?

**Dr. Appleford:** No.

**Mr. R. F. Johnston:** Thank you.

**Mr. Chairman:** Thank you very much, Dr. Appleford. We appreciate your attendance here.

**Dr. Appleford:** Glad to be in attendance, sir.

**Mr. Chairman:** Thank you for the information you have conveyed.

We have two people from the Humber Bay Child and Family Clinic. Dr. Danzinger, I believe, and Mr. Munro.

Do you have a statement?

**Mr. Munro:** Yes, I do. Mr. Chairman, and members of the committee. I am a social worker, the senior social worker at the Humber Bay Child and Family Clinic, and I am here today representing the board of directors and the chairman of the board of directors, Mr. Rod Stephens. Dr. Flora Danzinger is the vice-chairman of the board. The director of our clinic is Dr. Milton Marcilio.

The Humber Bay Child and Family Clinic is located on the grounds of Lakeshore Psychiatric Hospital, which is why we are coming before you in relation to the closing of Lakeshore Psychiatric Hospital. It is a community-based mental health program for children which emphasizes outpatient services as much as possible.

We have day-treatment programs; we have various community approaches that we use in avoiding the use of residential service. We have 25 inpatient beds which we use for children between the ages of about six, and sometimes even younger, up to about 16 or 17 years old. We use them basically as a backup to an outpatient service. We keep children as inpatients for short periods of

time in order to prepare them for return to the community—to their own homes or to group homes and so on.

I don't know how much you know about our services so I thought I would just give you a bit of background about it.

In 1967, the Ministry of Health proposed that there should be cutbacks in our unit. As a matter of fact, it was to be chopped up—

**Mr. Duksza:** Mr. Munro, you mean 1977?

**Mr. Munro:** Yes, it seems longer than that.

As a matter of fact, the proposal by the ministry was very similar to what's being proposed for the entire hospital now. We were to be chopped up in little portions and divided around Etobicoke and other parts of Metro. This brought a lot of public pressure from the community. Mr. Lawlor will remember attending a number of meetings, and a number of the local municipal politicians were involved at the time too.

A committee of inquiry was set up by the Minister of Health at the time to look into things. It was composed of two administrators and two psychiatrists. It concluded that the children's unit should continue to exist separate from the hospital as a whole, and that it should be moved to the community at the earliest possible time under a community board.

The minister then confirmed that was what he believed should happen and made a commitment that we would be relocated at an early time. As a matter of fact, the ministry at that time was speaking of a period of about six months during which we would be moved to the community off the grounds of the adult hospital. The latter was not seen as an appropriate place for a children's mental health centre, as I am sure you will agree.

The community board was established and has been operating for about three years now. Since that time it has continued, as have the senior staff of the unit, to work toward some form of divestment where we would be independent and operating under the board and not directly under the ministry as part of the psychiatric hospital.

During the course of that period of time, and recently particularly, two problems have impeded the progress of divestment. One is the decision by the government to switch us from Health to ComSoc. The second is the closing of Lakeshore hospital, which leaves us with an immediate problem of where we would be located if the buildings are closed.

According to the ministry, they plan to switch us from one ministry to the other on May 22, or thereabouts, or begin to plan towards that switch at that time.



I should say also that in preparation for divestment, another and independent review of our services was conducted by some quite well known people, including Dr. Taylor Statten, the chief of psychiatry at the University of Toronto, Dr. Lister and Mrs. Horne, who is associated with the McMaster medical centre.

The report was quite favourable to the kind of services we are providing and it concluded that the Humber Bay Child and Family Clinic "provides a unique and much-needed service in the community and should continue to receive support from the Ministry of Community and Social Services." The second recommendation: "The unit should be separated administratively and physically from Lakeshore Psychiatric Hospital as soon as possible." A third: "An expanded board of directors should assume responsibility for governing the Humber Bay Child and Family Clinic." They also said that if the services cannot be relocated immediately, the existing services should be upgraded and the unit's unique service to families through multi-family therapy merits recognition by teaching institutions. It had recommended an alliance with a university in that regard.

The reason I have come before the committee today on behalf of the board of directors is that it appears more and more clear, as the shift from one ministry to the other occurs, we are going to be shortchanged. If you look at our budget as a separate unit within the whole, it mainly consists of staff salaries and fringe benefits to staff. The actual cost of all the auxiliary services that have been provided through the hospital and through the huge plant that operates there—simple things such as postage, gardening, heating and all the things that are involved in that—has not been included in the proposed changeover.

As a matter of fact, the ministry people themselves admit that this will mean a reduction of our budget. Considering the very high demands that are on our services at the present time and have been for some time, and the response of the community several years ago when there was a threatened cutback, we are in the position where we don't really know to whom to bring our concerns that our budget is being cut at this time. We are caught in some ways between the two ministries and we really want to let people know that this is part of the problem related to the closing of Lakeshore. Perhaps I can finish now and ask if there are questions.

**Mr. McClellan:** I have just one quick question for clarification. Are you still formally under the Ministry of Health?

**Dr. Danzinger:** We are in a transition period. The major problem is that the actual budget, which comes from ComSoc at present, is just under \$1 million, which covers salaries and fringe benefits. At the present time, Lakeshore Psychiatric Hospital, and therefore the Ministry of Health, is still providing all other services.

**Mr. Duktzta:** Before I ask some questions, I should state that I am on the board of the children's unit. I didn't perceive its being involved in the closure of Lakeshore until I attended the board meeting the day before yesterday. It came to the conclusion, in spite of what I originally thought, that the money would be coming from ComSoc, there was a very significant amount of money which at the moment is given to support the services from the Ministry of Health. This has direct implications on our decisions here because we need to establish how much it is and we need to establish how it is going to be picked up.

As Mr. Munro stated, it is a significant infusion of funds just for the buildings, maintenance, gardening, and almost any of those things which are not now allowed for. I don't know in a strict sense what we have to do about this, but at least we should be aware that this is one of the implications.

**Dr. Danzinger:** May I add for your clarification that ComSoc has stated that it has no money available to cover the difference? Therefore, if the budget from ComSoc remains the same and the other services have to be covered, there will be a drastic cutback in programming and a drastic cutback in services to children and youth in that area, where there already have been drastic cutbacks generally, which are more than can be tolerated.

**Mr. Duktzta:** My questions actually involve details about that. For the record and for the other members of the committee, you should specify exactly the extent of the services you are providing. First, this thing that you brought up, that there was no further money, could you be specific about this for the committee?

**Dr. Danzinger:** What the cutbacks are likely to be?

**Mr. Duktzta:** Yes.

**Dr. Danzinger:** Yes, I think Mr. Munro can speak best to that because he works directly with the unit.

[4:45]

**Mr. Munro:** One of our difficulties at the present time is neither the staff nor the board has had control over or even actual knowledge of our budget. It's difficult even for the administration of the hospital to estimate how much a share of the heating bill, for instance, relates to our particular unit.

If we were to operate independently in a separate building, our costs for those kinds of things are going to be a lot more than they are now. There is absolutely no provision in the new budget that ComSoc is looking at at the present time for replacement of furniture, for instance. There is not a cent in there for replacement of the vehicles we use to transport the children to activities in the community. There is no provision for these sorts of things.

For instance, clinical records have been maintained by the hospital as a whole. We have no idea at the moment what that is going to cost us to do ourselves. They have done a lot of administrative functions—the personnel department, all these things, have not been included in the proposed budget that is going to be shifted from one ministry to the other.

In terms of the actual amounts of money, I'd rather not say, because we need to do some more homework ourselves in order to become more understanding about exactly what the figures will be. The Ministry of Community and Social Services has suggested a figure of \$1 million as the money that would be transferred from one ministry to the other. I know that our present budget for staff and fringe benefits alone is in the neighbourhood of \$900,000. Therefore you can well imagine the other expenses are going to amount to a lot more than \$100,000. What concerns us, and the children we serve, is we are going to have to cut back our services if something isn't done. And that's really why we come before you as I say.

**Mr. Duksza:** I think it's a very worthwhile unit and it has been recognized by the successive ministers, especially by the Acting Minister of Health in the past, Dr. Stephenson. There is a role and function for this unit and the direct provision of direct care and psychiatric services for children. Clearly there has been a commitment. I will ask them in turn to work out in much more detail the cost of the service, because surely we will have to take that into consideration, when we are—if we are—making a decision to close Lakeshore, and exactly what is going to be saved, how much it's going to cost. When we are providing for all those services now that they're going to be thrown out, exactly how

much is the ministry going to save after all this?

To establish the case a little bit further and for the benefit of the committee and those who read the transcripts later, I would like Mr. Munro to make a statement on exactly what kind of service they are providing.

**Mr. Munro:** When the present director of our unit came to the hospital it was very much a custodial kind of treatment program. Children came and stayed for two years and they were often transferred after that time to the adult wards. There was a great deal of that sort of thing. There was very little or no outpatient work done at that time.

Dr. Mercilio, with the experience that he had, came to us and transformed the place. He believed from the very beginning that we should look at inpatient service only as backup service, a backup to a good outpatient approach.

From that time, we've moved into the community. We provide direct service to the board of education. We are now known directly to many schools in the area, and they refer directly to us.

We provide as immediate an assessment of the families as we're able to. And then offer a variety of services. One of the things we try to do is offer immediate service. Once we've seen the family we provide the service ourselves, rather than refer them elsewhere, and if they need to be admitted, we try to make sure that we can do that immediately. We work very closely with families.

One of the other significant things is that we involve a number of professional people from the community, as volunteers. We have people who are probation officers and senior people on different agencies in the community who participate in our multiple-family group therapy program. We have about 13 multiple-family group therapy programs going on each week. This means seeing several families together. This is one of the unique approaches that Dr. Mercilio has developed in the unit and it has been extremely effective.

Connected with the unit we have a day school which serves 10 day-care patients. Young people come to us from all over the city—Etobicoke particularly, but other places too. That's another thing; our service is available to anyone. We don't have a catchment area, we haven't got a defined area.

Dr. Mercilio and other staff's knowledge of a variety of languages and his knowledge of the Italian and Portuguese communities has been particularly helpful. We have a



variety of play therapy groups—that sort of thing.

**Mr. Duksza:** One thing you did not refer to was your inpatient facilities—how many beds do you have?

**Mr. Munro:** We have 25 beds at the present time.

**Dr. Danzinger:** I wonder if I could add something to that. I am also the director of an outpatient clinic which is situated in the west end of Toronto and many of our patients are Italian- and Portuguese-speaking. It's a very working class multiproblem area; many of our patients do need emergency admission. Many children do need immediate treatment. That is the one unit where I can be assured of an emergency admission.

We are treating on an outpatient basis many children who we would not take on if we did not have the reassurance that quick admission is available as a backup. So I am also speaking as the director of an outpatient service, which has no backup of beds, but the use of the facility at the Lakeshore hospital and I am sure that there are many others in that same position.

**Mr. McClellan:** What is the outpatient service called? Is it one of the Lakeshore's outpatient services?

**Dr. Danzinger:** No, this is quite separate. This is in the borough of York and it's associated with the municipality. It's the Borough of York Child Guidance Clinic; it's an outpatient service.

**Mr. McClellan:** Yes, thank you.

**Mr. Duksza:** Mr. Munro, you have attempted to find a place in the community to relocate, including the beds. Am I correct?

**Mr. Munro:** Yes, the board has been quite active, I believe, in trying to locate a building in the community that we might move to. Our feel is that the minister made a very strong commitment that we would be moved to the community and go under a private board. This has not happened and it's been quite a few years. Before everything's transferred to another ministry, we feel that the Ministry of Health has the obligation to be concerned about our relocation and to make sure that our budget is adequate in the new location.

Now at the moment there's no particular place in mind. We are still in one of the buildings on the hospital grounds that some of you I gather have seen. I don't know if we're going to be able to stay there, or if it will be possible to move to any other buildings on the grounds—we're not sure of

this at the present time. All these things are very much up in the air in regard to—

**Mr. Duksza:** Have you participated in that committee of Dr. Lynes? Have you had input into that committee which is planning disposals? Have you been participating in any committee about disposal of your unit?

**Mr. Munro:** Not myself.

**Mr. Duksza:** Has anyone contacted the board?

**Dr. Danzinger:** I think Mr. Stephens, the chairman of the board, has been involved.

**Mr. Conway:** But you, as such, have not been?

**Mr. Munro:** No, I haven't.

**Mr. Duksza:** It's not only that 25 beds, but you've also an extensive outpatient facility centred on the unit on the grounds of the Lakeshore, isn't it?

**Mr. Munro:** Yes, that's correct.

**Mr. Duksza:** Could you specify how extensive that service really is?

**Mr. Munro:** We see an average of about 350 outpatients a week, on a regular basis.

**Dr. Danzinger:** It's very cost effective.

**Mr. Duksza:** Yes, it is cost effective.

I just wanted to establish those points that we must take into account.

**Mr. R. F. Johnston:** On a point of clarification, I'm just not sure what the backup is that we're talking about. Is it a medical backup?

**Dr. Danzinger:** You mean the beds as a backup?

**Mr. R. F. Johnston:** Yes.

**Dr. Danzinger:** Because many of these families are very stressed and troubled, it is the knowledge that should a crisis arise, especially where children are extremely disturbed, the backup is the support that a bed can be made available. Some families are prepared to keep the children at home if they know there is an emergency support service available.

**Mr. R. F. Johnston:** So therefore it wouldn't matter to you if you had your units set up with inpatient capability in the community or in Lakeshore hospital as long as you had your present staff available for that?

**Mr. Munro:** That's right.

**Mr. R. F. Johnston:** The rest of the hospital does not really provide any backup?

**Mr. Munro:** No.

**Dr. Danzinger:** No, except that its imminent closing does have very serious repercussions.

**Mr. R. F. Johnston:** Right, okay.



Interjection.

**Dr. Danzinger:** With sufficient funding to make up for the services which are now being provided at the Lakeshore.

**Mr. Conway:** Your testimony is most helpful. Certainly one of the key questions this committee must determine is the condition of allied services. You are a service about which I knew very little prior to your arrival here today, and I dare say most members of the committee probably shared of that ignorance—those of us at least from the non-Toronto area. My colleague, Mr. Blundy, the Liberal Social Services critic, I think indicated it in an aside earlier—if his experience and the experience of others here is any guide—but what is the likelihood of your ability within the next year or six months to find appropriate relocating facilities?

**Dr. Danzinger:** It's very difficult, very unlikely. Our board has been looking for three years. It is especially difficult if there is no fund available to make the relocation possible, but even not considering that, it is very difficult.

**Mr. Conway:** We are told that as of September 1, the Lakeshore facility is to be pretty well phased out under the minister's January 22 announcement. Have you any reason to believe you're not part of that movement as far as the September 1 deadline is concerned?

[5:00]

**Mr. Munro:** I must say, it is a very great concern to us that this date is being talked about when we have nowhere to move to. It was of very great concern to us when someone representing the ministry came to us and said it didn't really matter to them if we stopped our services for a period of time while we found a new place and got ourselves settled in it.

I cannot understand how we can just drop services to all the community agencies, and all the families and children we serve for a period of several months or even a period of one month while we are relocating. We have operated full tilt and full out ever since before the time of the threatened closure. All of the reports that have been done about us speak to the volume and the quality of the work we have been doing in the community. We can't stop that all of a sudden. It's just not fair to the families even to consider that.

**Mr. Conway:** As far as you are aware, there is no exemption from the September 1 deadline for your unit.

**Mr. Munro:** I understand there has been some consideration of our using another building on the property, but that building is presently used by the outpatient services

which also have nowhere to go. They would like to continue operating where they are. One person is saying that the building might be available, while other people are saying that it is not available because that outpatient service will continue.

I must say we have been operating a child and adolescent unit of, I believe, very superior quality in a building which is completely inappropriate for the kinds of things we do because of the recreation space, the bathroom space, the way the rooms are designed and the fact that the wind blows through the windows. You know all this about the hospital as a whole. The problem is, how can we operate properly unless we are given adequate facilities?

The major cost of a children's mental health centre always is the staffing. I believe that what we need is a new facility. We have been trying to use a shoehorn to stick ourselves into various buildings available in Etobicoke. We have looked at the old firehall and the old police station. We have looked at this building, and we have looked at that one and we cannot find any facility which is appropriate.

In the long run, it is going to cost more and be much less effective than for us to have an adequate, proper facility to do the job we believe we can do.

**Mr. Conway:** You are the child and adolescent unit. I was confused in my initial thought in that connection. I am sorry for having been misled in that regard. I'm afraid I was thinking of something else. I did, in fact, mislead myself, as the member for Bellwoods points out.

**Mr. McClellan:** I gather there has been some discussion as recently as this morning with respect to a proposal to move your unit to the Humber building on the Lakeshore grounds. Is that news to you or is that something you participated in? Secondly, is it an adequate facility to accommodate your unit?

**Dr. Danzinger:** The Humber building on the Lakeshore grounds? Is that the nurses' residence?

**Mr. Munro:** That is the building nearest to Lakeshore Boulevard.

**Mr. McClellan:** Yes.

**Dr. Danzinger:** Two days ago our information was that that building would not be available.

**Mr. Munro:** That's the building I was speaking of.

**Mr. McClellan:** Is it suitable?

**Dr. Danzinger:** Many alterations would have to be made.

**Mr. Munro:** I haven't explored the building thoroughly. As far as I know, there is no recreation space in the building. The building basically operates on a central hall system with rooms off one side and the other. I think it would be very costly to make it appropriate for our facilities, but I really don't know whether it's appropriate or not.

**Mr. Duksza:** And for how long.

**Mr. McClellan:** I won't pursue questions now as we will have an opportunity tomorrow when we are visiting. The committee is visiting both Lakeshore and Queen Street tomorrow, so we'll have a chance to see the facilities and talk some more about it then.

**Mr. Munro:** I say, you are very welcome to visit us and various members of our staff can answer questions for you and discuss any things you might have at that time.

**Mr. McClellan:** Right, good. Thank you.

**Mr. Lawlor:** I'd like to make a brief statement on this particular point before we finish.

This isn't the first occasion upon which the Ministry of Health has either threatened or made forays upon the Lakeshore Hospital during my 12 years as representative of the area. I have been particularly cognizant of three or four, but three years ago is the one you mentioned, with respect to the adolescent child care unit. I won't prolong it, I will simply say at that time a search committee was set up to find alternative facilities; you mentioned a firehall, and a police station which was a fairly large building, whether it was suitable or not. The residents in the area objected so strenuously particularly to that abandoned police station that you have never been able to find a spot to which to go. I do not believe, as the member, there is any such suitable facility for their accommodation. They simply will have to remain on those premises.

I had thought the transfer to ComSoc had been consummated, you see. Even as the member, I have to confess ignorance. It shocks me to learn this afternoon—

**Dr. Danzinger:** Partially, it seems to be a shared arrangement at the moment.

**Mr. Lawlor:** —of a kind of working, shared arrangement. The minister constantly tells me it's not his responsibility, and he has no role in the matter at all. He told me that personally in his office when I met with the full staff a month and one half ago.

**Mr. Munro:** Which minister?

**Mr. Duksza:** The Minister of Health.

**Mr. Lawlor:** The Minister of Health, perfectly right.

**Dr. Danzinger:** But the Minister of Health is still providing the building, the services, the linen, the food.

**Mr. Lawlor:** Well, the minister came before this committee on April 23 and gave us a detailed statement which made no mention whatsoever of this particular difficulty. I am very pleased that you attended today to clue us in. What the hell is going on?

**Dr. Danzinger:** That's why we decided to come.

**Mr. Lawlor:** Thank you.

**Mr. Chairman:** Mr. Kennedy.

**Mr. Kennedy:** Is your service deemed to be one of the outpatient services of Lakeshore Psychiatric? Is it correctly described as one of them?

**Mr. Munro:** No, this gentleman's confusion about whether we are the child and adolescent unit or not is not unusual, because, in fact, we have a private board, we have a board of directors, we are incorporated under that board of directors, but we are still partly responsible to one ministry, and partly responsible to the other ministry. It's very confusing for the community, the local member, as well as all the people who are connected with the agency to quite understand where we stand at the moment.

**Mr. Kennedy:** Are you saying the local member is confused?

**Mr. Lawlor:** The local member is kept in the dark as much as possible.

**Mr. Munro:** No, in answer to his question, we are not an outpatient service.

**Mr. Duksza:** So who is confusing whom? The minister assured Mr. Lawlor.

**Mr. Kennedy:** I don't want to assure you, I just was attempting facetiousness.

**Mr. Chairman:** We won't get into that.

**Mr. Kennedy:** No, then really what you are doing is using some physical facility that is there.

**Mr. Munro:** Yes, that's it.

**Mr. Kennedy:** I went by that building.

**Mr. Munro:** That's correct.

**Mr. Kennedy:** The Minister of Health, in a statement of January 22, said these outpatient services would continue with no disruption of service. This is in his statement. What I am trying to get at is whether you would come under that encompassing statement.

**Dr. Danzinger:** No, I think the unit was simply overlooked in the statement.

**Mr. McClellan:** There were many things overlooked.

Mr. Duksza: You musn't be so clear, Dr. Danzinger.

Mr. Kennedy: I wanted to clear that up and I think it could very well be taken up with ComSoc. Thank you very much.

Dr. Danzinger: Thank you for listening to us.

Mr. Chairman: Thank you.

Mr. Conway: I do think the committee is going to have to seriously evaluate that evidence. I apologize, I didn't realize your full title. I knew what you were, but I don't think I had ever really heard the full unit title.

Mr. McClellan: I had understood you were someone who was familiar with the clinic, but I had not understood your ongoing relationship with the Ministry of Health and the hospital. I am profoundly alarmed.

Mr. Chairman: Thank you very much, Dr. Danzinger, and Mr. Munro. We appreciate your appearance.

The committee does have the agenda for tomorrow, so we'll meet out front at 10 bells.

Mr. McClellan: Well, I was rather startled when I saw we were going to have no cross-pollination, but I guess that's the way it's been arranged.

Mr. Duksza: It's what we've been saying—a grand coalition of Liberals and Conservatives.

Mr. Lawlor: With much more rhetoric Duksza, your hope for a majority consensus may evaporate.

Mr. Chairman: The taxis meet us out front at 10 a.m.

The committee adjourned at 5:11 p.m.



### SPEAKERS IN THIS ISSUE

---

Conway, S. (Renfrew North L)  
Duksza, J. (Parkdale NDP)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Kennedy, R. D. (Mississauga South PC)  
Lawlor, P. D. (Lakeshore NDP)  
Leluk, N. G. (York West PC)  
McClellan, R. (Bellwoods NDP)  
Ramsay, R. H. (Sault Ste. Marie PC)

**Witnesses:**

Appleford, Dr. R. D., Medical Director, Peel Regional Health Unit.  
Danzinger, Dr. F., Vice-chairman of the Board, Humber Bay Child and Family Clinic.  
Munro, D. R., Senior Social Worker, Humber Bay Child and Family Clinic.  
Richardson, H. E., Executive Director, Canadian Mental Health Association, Ontario Division.









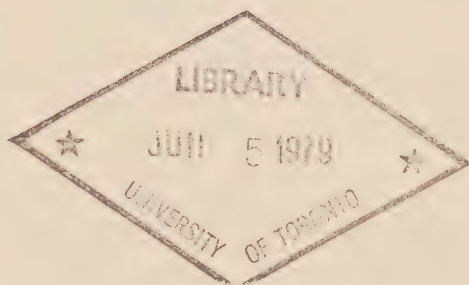
No. S-14

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Monday, May 14, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the **Hansard Reporting Service indexing staff** at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.

Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

MONDAY, MAY 14, 1979

The committee met at 3:20 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78.

(continued)

**Mr. Chairman:** I think the committee should proceed. We have a rather heavy afternoon. As always, time is a problem with us. We have as our first witness Dr. Guirguis. I think the committee's interest is obvious, Dr. Guirguis, in view of your letter addressed to me, which I received late Thursday afternoon. I think the committee wanted to review that letter with you, sir, if they could. Do you have any comments beyond the scope of your letter which you would want to make initially?

**Dr. Guirguis:** They are being made, as you realize, on behalf of the medical staff of the centre, and I think it's important that I point out that, for one thing, we had no anticipation of the kind of impact this letter had. Also it should be quite clear that no political intention behind it was intended in any way or form.

**Mr. Chairman:** Right. I should indicate to the committee that Dr. Guirguis has had to rearrange his schedule at very short notice, and I believe you have to leave at four, sir.

That being the case, I would prefer to allocate 15 minutes to each of the parties, and that would allow Dr. Guirguis to retire at 4. Mr. Conway?

**Mr. Conway:** Your letter, Dr. Guirguis, has indeed inspired a considerable degree of interest in the press, and looking around the room, you, unlike many of your predecessors at the witness stand, have brought out some of the heavy artillery from the ministry, I notice. So I must say that I found your three-page, multipoint presentation of very considerable interest. I'm wondering—and I don't want this to be a leading question—but you, as the chairman of the Medical Advisory Committee wrote this letter, I believe, on May 10. Our hearings began about a month ago.

I'm wondering if I might just ask, was it the intention of the Medical Advisory Com-

mittee to author such a letter? If so, could you perhaps indicate why it is that the committee, the MAC, waited as long as it did? Were there, for example, certain testimonials here you felt compelled to respond to? Could you just indicate why your letter was dated May 10 and perhaps not a little earlier?

**Dr. Guirguis:** One or two points—for one thing, we as medical staff weren't terribly aware of this committee's existence, of its function. I'm sorry if that dismays you. Then it became apparent; as we heard of people from the hospital and from different parts of the centre being called to the committee we became aware of its existence.

I don't think that the timing has been something that we thought out, particularly, except that we felt, as medical staff, that we had an input. We had something to say about what is happening. We're the people who are directly responsible for patient care. We would like to bring our point of view across. Our intention was indeed to do that and make sure it is understood rather than perhaps what has happened here, that it may have been subject to certain misunderstandings. We are concerned that this shouldn't be the case.

**Mr. Conway:** Your letter leaves a very, very strong impression and indeed statement that the want of wisdom in the closure of Lakeshore is most explained by what you perceive to be—a complete extreme lack of time for planning, is the phrase—an extreme lack of planning generally. Is that a fair assessment of the position the MAC has taken, that there really is an absolute absence of any systematic planning with respect to the closure of Lakeshore?

**Dr. Guirguis:** That is not so much the case as the concern of the medical staff of Queen Street to have input in the process, in whatever is going on. It's on that basis and, as it were, the need to be heard, and our concerns be looked at and considered, and become part of the planning process. I think it's important to point out that we are not in a position, nor do we want to, to comment on the closure decision itself. In fact, I don't know if anybody can. This is not our intention.



Mrs. Campbell: You'd be surprised.

Mr. Conway: The severe overcrowding of which you speak at the bottom of page one—

Dr. Guirguis: Yes.

Mr. Conway: —occurring between mid-February and mid-April, is that the kind of condition that we can expect to continue at Queen Street if something is not done to alleviate the planning problem that you faced in the past four months?

Dr. Guirguis: Not necessarily. I don't know which way things will go. But I do know that with a certain amount of planning, a certain amount of preparation, this situation can be avoided, and can be dealt with. I think this is the point, again, we're trying to bring across, but it would be difficult to—I can predict one thing, someone else equally competent in that area can predict another. I don't know who would be right. There is a chance to avoid the deleterious effects of overcrowding.

Mr. Conway: What is the nature of the chance to avoid the overcrowding to which you've directed our attention? What would have to be done to alleviate that burden?

Dr. Guirguis: We would want to—and I think this is going to happen—get involved in the process of planning, in organizing, helping to organize a smooth transfer of patients, attempt to make a studied prediction of the future impact, and prepare for it.

Mr. Conway: What evidence have you to indicate that there will be some chance for this planning to occur? For example, since the letter was sent to the chairman, May 10 being last Thursday, have you been contacted by any of your senior officials in the psychiatric services branch of the Ministry of Health with respect to this?

Dr. Guirguis: Yes.

Mr. Conway: Could you indicate to the committee when that communication was made, by whom it was made, and the nature of that contact such as to make you now believe that there will be a possibility for such planning that was clearly not prepared or allowed earlier?

Dr. Guirguis: We met with a group of senior officials from the ministry—

Mr. Conway: When?

Dr. Guirguis: This morning.

Mr. Conway: At their invitation?

Dr. Guirguis: Yes, the Medical Advisory Committee as a body, not just myself. We discussed our concerns and it was indicated to us that certainly we would be involved in the process of the planning, and that we

would be able to have input and that our concerns would be listened to and our opinions sought and consultation would take place.

[3:30]

Mr. Conway: Can you indicate the time frame? We are now looking at a ministerial order that would close Lakeshore completely, or by and large completely, by September 1. Is that in your view a realistic deadline to allow for the sort of planning of which you now make mention?

Dr. Guirguis: I can't say until we actually sit down and see the kind of things—there are certain things I would like to see happen, other colleagues would like to see happen, each in relation to the catchment area they're responsible for. So it is really not possible to talk in terms of a specific time framework. I understand that there may be a certain amount of flexibility in that area, but I don't know about the time framework, and I wouldn't like to predict one.

Mr. Conway: Your letter leaves a very clear impression that such overcrowding, as you have described, between the period mid-February to mid-April has, in your own words, led to inevitable risks with respect to premature discharge of some patients, and such other examples that I think would lead the reasonable man to conclude that the quality of health care being provided to psychiatric patients in Metropolitan Toronto is, as of this point in time, being severely compromised by virtue of this unplanned closure of Lakeshore. Is that an unreasonable conclusion on the basis of your rather strong three-page letter?

Dr. Guirguis: Well, I don't suppose on the strength of my letter, but maybe my wording, or the wording of the authors—there were three of us together who composed the letter on behalf of the medical staff—was meant to indicate the inherent risks in a process. So far nothing disastrous has happened. That's because the staff have been doing what I think is an extremely good job. There has been a certain amount of discharging of patients a little bit sooner than we would have liked, but there has been no staff psychiatrist that I know of, and we have discussed that, at least in my service, who has taken an excessive risk that in fact would put them in jeopardy of exercising poor clinical judgement. No staff psychiatrist I know of in Queen Street would do that. So although there has been some certain amount of premature discharge, it hasn't been at the risk, say, of discharging a suicidal patient or a

homicidal patient. Nothing like that has happened.

**Mr. Conway:** Just two further questions, doctor. One—and I want to be clear about this—the minister made his announcement about the closure of Lakeshore on January 22. This committee began its deliberations at least three and a half weeks ago, and probably more than that. It was not until this morning, May 14, that there was any official contact between the Medical Advisory Committee at the Queen Street Mental Health Centre and the psychiatric services branch at the Ministry of Health. Am I correct?

**Dr. Guirguis:** No, I'm sorry. You're not correct. There has been contact between ourselves and—I don't know exactly their designation, but certain senior members who have come down to the centre on more than one occasion to speak to us. However, that has not been necessarily in the context of preparing or having a plan and knowing what to work with and what resources and so on, it was a question of discussing, "This is the situation now. What are we going to do about it?" and so on.

There have been some contacts of that nature and we have, as medical staff, conveyed through Medical Advisory Committee meetings and medical staff meetings and our continuous, I may say, participation in local planning at the hospital level. That's been happening. I don't know how much of that's been carried back.

**Mr. Conway:** But this morning's meeting was the first more or less systematic approach, from both the ministry's and your Medical Advisory Committee's point of view, with respect to planning some of the fundamental things that need to be planned for, if this move is going to occur, and this indeed occurs about four to five months after the initial—

**Dr. Guirguis:** At my level, yes.

**Mr. Conway:** Just a final point. There has been a great deal of debate in this committee about the capacity of Queen Street to deal with an additional inpatient load, with the ministry arguing, I believe, 217 extra beds and the union, OPSEU, arguing I think about 60 per cent of that. How do you feel, and how does your committee feel, with respect to the ability of Queen Street Mental Health Centre, within the foreseeable future to accept the present patient load that is at Lakeshore and is likely to grow out of that catchment area?

**Dr. Guirguis:** The present patient load, I think, can be taken over at Queen Street. I don't think there's much argument with that.

I think we indicate that we acknowledge that fact. It is the process of the taking over, how it's done, and we can prepare for it that we are concerned with. So I don't think there's much problem with space and facilities.

**Mr. Conway:** Does that mean that Lakeshore, as it presently exists as a facility, is in the view of your Medical Advisory Committee redundant from the point of view of meeting the needs of the inpatient requirements for that catchment area?

**Dr. Guirguis:** No, I'm afraid that doesn't follow. The point is that we have the space and the facilities. I can't say whether Lakeshore is redundant or not. I don't know.

**Mr. Conway:** What would you need to know? What, in your view, would this committee need to know to make that judgement which the ministry has on the basis of what appears to be a striking want of evidence, judged as of January 22?

**Dr. Guirguis:** I can't speak for the ministry, but I understand a little bit about what goes on with the economic situation and so on. We've all gone through budgets and so on. I can see that there may be certain economic restrictions that make it necessary to use space that is available and, in fact, extremely modern, which we have. I can't tell you whether by the same token that Lakeshore is no longer useful or whether it should continue. I don't know.

**Mr. Conway:** Just to conclude then, Mr. Chairman, my impression is that you can see the budgetary imperative but no good immediate health-care planning requirement that would phase out Lakeshore.

**Dr. Guirguis:** Well, I don't like to be arrogant, but I think if we had facilities and resources we could do a very good job.

**Mr. Conway:** Facilities and resources that are not yet allocated to you under any plan you are aware of, I presume?

**Dr. Guirguis:** Well, I understand we're now going to be involved in that.

**Mr. Conway:** Thank you very much, doctor.

**Mr. Chairman:** Mr. Lawlor?

**Mr. Lawlor:** You, doctor, are the chairman of the Medical Advisory Committee. Can you give us an idea of who constitutes that committee?

**Dr. Guirguis:** Excuse me one minute. I'll tell you exactly. Here we are. President of the medical staff; vice-president of the medical staff; the secretary of the medical staff; who will also act as the secretary of the Medical Advisory Committee; treasurer of the medical staff, the medical director, ex-



officio and non-voting member; the chiefs of services—we have three geographic services and one psychogeriatric service covering the whole catchment area—that's four; the director of education and research; one representative of the psychiatric staff who is not a chief of service; one representative of the physicians who are not on the psychiatric staff; the chief resident; and the administrator as an ex-officio and non-voting member.

**Mr. Lawlor:** So it's a committee very representative of the medical staff.

**Dr. Guirguis:** Yes.

**Mr. Lawlor:** And you have, what, 18 psychiatrists on staff at the hospital?

**Dr. Guirguis:** I can't tell you exactly. I think 19 maybe. I'm not sure.

**Mr. Lawlor:** And the nursing staff. Do you know the number?

**Dr. Guirguis:** I think there are some 300 or thereabouts. I don't know these figures accurately, I am afraid.

**Mr. Lawlor:** All right, I won't press you on it.

And you saw the ministry this morning; that's always very interesting. When did the ministry get in touch with you and summon you to, or, as Mr. Conway says, invite you to come in?

**Dr. Guirguis:** The medical director asked us to come down, so we came down.

**Mr. Lawlor:** When, this morning? Or over the weekend?

**Dr. Guirguis:** Yesterday.

**Mr. Lawlor:** Yesterday, Sunday.

**Mr. Conway:** What time yesterday?

**Dr. Guirguis:** The medical director and chiefs of service are always in contact even over the weekend. There is nothing unusual about that.

**Mr. Duksza:** I think a 24-hour decision to call the staff together to plan the changeover is reasonable, isn't it, according to the ministerial rules?

Interjections.

**Mr. Conway:** Just as a matter of interest, was it before the newspaper article appeared?

**Dr. Guirguis:** Yes.

**Mr. Lawlor:** And how long did you spend with that magnificent staff?

**Dr. Guirguis:** A fair bit of the morning. I didn't check my time exactly, but I think we left around mid-day.

**Mr. Lawlor:** Can you tell me an hour or two hours?

**Dr. Guirguis:** Yes, a little over two hours.

**Mr. Lawlor:** So it took them two hours. I see. May I ask you, doctor, do you stand be-

hind the statements you composed a few days ago, on May 10?

**Dr. Guirguis:** How do you mean, do I stand behind them?

**Mr. Lawlor:** Do you reaffirm those statements before this committee today?

**Dr. Guirguis:** Yes, they are there.

**Mr. Lawlor:** Do you believe they are true and that they represent the basic feeling of the committee?

**Dr. Guirguis:** Yes, they present the feelings of the medical staff. As to some of the assumptions we have made on the basis for which the ministry has acted, that I can't say. We are simply expressing our feelings as medical staff.

**Mr. Lawlor:** Thank you. Were you consulted in any personal way by the McKinsey study group?

**Dr. Guirguis:** No. In my capacity as chief of service I was consulted way back when they were doing their study, yes.

**Mr. Lawlor:** On numerous occasions?

**Dr. Guirguis:** I can't remember what they were up to. They prepared a number of questionnaires and schedules that we had to help fill in and work out and we did that. On a couple of occasions they gave us feedback on how far they had got with the report, and that was about it. I can't remember exactly what went on in these. It was a while back.

**Mr. Lawlor:** Have you studied the McKinsey report yourself?

**Dr. Guirguis:** No, I looked at the portion of it that was available when it came out and read it through briefly. I know bits of it but I haven't studied it.

**Mr. Lawlor:** Have you any comments about it as to the contents that you are aware of? Is it a good report, do you think?

**Dr. Guirguis:** I think it was a good report. As far as I can remember, I think it was a good report.

**Mr. Lawlor:** You say, just above (a) on the first page: "The immediate adverse consequences of this hastily rushed, unprepared decision included," and then you give a list of things. Are you still of the opinion that it's a hastily rushed and unprepared decision?

**Dr. Guirguis:** I think you should see those comments in the context of our desire to be heard. If there is a chance that we will be involved—and as I understand it we will be—in the planning and preparation, then I may have cause to change my opinion later on.



**Mr. Lawlor:** Let me put it this way—and I would never want to be accused of badgering the witness, you know.

**Mrs. Campbell:** No, you have been leading the witness.

**Mr. Lawlor:** But certainly up until a day or two ago it was, in your opinion, a hastily rushed and unprepared decision?

**Dr. Guirguis:** Yes.

**Mr. Lawlor:** Mr. Conway asked you about your premature discharges. You go on to say: "In these crowded wards there has been an increase of disturbed behaviour, leading at times to the locking of doors of open wards and a higher incidence of injury to staff and patients." Would you care to comment on that?

[3:45]

**Dr. Guirguis:** Yes. Overcrowding creates a difficult situation because it prevents us from following through with therapeutic programs that we have designed to be carried out throughout the day. Also, there is a tendency when there is an amount of anxiety or concern amongst staff because of uncertainties and because of the overcrowding, to over-react and perhaps react less efficiently than we would like and the consequence is a tendency to lock a door when we have, in my service, a very clear statement about not locking doors.

**Mr. Lawlor:** But it is not just a tendency; I mean you actually lock doors now.

**Dr. Guirguis:** No, no, occasionally.

**Mr. Lawlor:** Occasionally?

**Dr. Guirguis:** I think we should make that point clear that these are periodic—say an hour at a time or a couple of hours at a time. I feel very strongly about that and it's my own therapeutic orientation that makes me always apprehensive about locked doors.

**Mr. Lawlor:** In paragraph (b) you speak of academic standards and the real concern of the staff at Queen Street with respect to maintaining your university liaison and a certain very high level of psychiatric care in what is going to be a very large hospital. You mention the transfer of the medical staff. Let me read the whole sentence: "Even by 8.5.79 we have had no written guarantee that the transfer of medical staff may not contravene the university agreement signed by Mr. Timbrell."

Did you have an opportunity in your discussions this morning, or have you since learned, as to the impact of these moves upon that agreement?

**Dr. Guirguis:** Yes.

**Mr. Lawlor:** Is it satisfactory?

**Dr. Guirguis:** Yes.

**Mr. Lawlor:** And are the medical staff bylaws adhered to?

**Dr. Guirguis:** Yes.

**Mr. Lawlor:** Then you make a further statement about the unhurried, well-prepared plan in this context and mention community services at Queen Street. You say: "Any planning, such as it is, has only created more uncertainty and confusion about existing and future community based services." I would like you to elaborate a bit on that.

**Dr. Guirguis:** Well, the planning for outpatient services and for the future needs of the patients on an outpatient basis is an integral part of the overall preparation for our centre to deliver services to this whole area. Here again we had not felt that, as medical staff, we were having sufficient input into the process and we were not able to gauge accurately what has been happening in the community in order for us to make preparations to act as the backup resource to these community-based services.

**Mr. Lawlor:** Are you any the wiser, sitting here today?

**Dr. Guirguis:** Well, I am more confident that what my colleagues have to say will be listened to and considered and become part of a more effective plan.

**Mr. Lawlor:** But is there anything more specific or concrete than that arising out of your conversations of this morning?

**Dr. Guirguis:** No, I am not sure. I can't say if there is anything more concrete than—

**Mr. Lawlor:** There was nothing more definite? Did you discuss housing problems or day-care centres in the community, or the care of chronic patients in certain kinds of homes, or anything like that?

**Dr. Guirguis:** Not on an outpatient basis. We simply talked about the outpatient services as a whole, which involves all the factors you mentioned.

**Mr. Lawlor:** And then you go on on the overcrowding and say: "There has been a marked 34 per cent increase in admissions referred from other hospitals in our old catchment area during January-mid-April 1979, compared with the same period of 1978. This is possibly related to budget cuts in these hospitals."

Have you anything more definite or specific about this possibility being related to budget cuts in other hospitals and they are referring matters over to you therefore?

**Dr. Guirguis:** Well, nothing concrete. We hear from colleagues. When we communicate

with other hospitals we hear what they are going through in relation to fiscal constraints and so on. It is conjecture on our part that this may be the contributing factor to their limiting their services and that we are therefore getting more and more of it. We point out the figures.

**Mr. Lawlor:** Again, during your discussions this morning did the ministry advert to that particular paragraph of your statement and give you, I trust, some kind of concrete assurances that that simply wasn't the case?

**Dr. Guirguis:** That what was not the case?

**Mr. Lawlor:** That you were not, because of budget cuts and other hospitals—that's general and psychiatric—being visited with a patient clientele you otherwise might not have had. In other words, they haven't got the money and they have given the job to you.

**Dr. Guirguis:** Well, they didn't tell us that.

**Mr. Lawlor:** They didn't tell you. They didn't discuss that with you at all. I see.

Then, on page three you have a grave concern with this very expanded catchment area having to do with distance, and you are worried about acute services being transferred to the hospitals in the area, and you, being left with a range or kind of patient, et cetera, that is not particularly amenable to your university function, to your teaching hospital concept; you use the word dumping—is that an ongoing and constant concern and was that discussed this morning?

**Dr. Guirguis:** Yes, I think that most of these points should be looked at in the context of our concern to prepare and to make plans, not in the context of our inability to do the job. If you look at the Lakeshore Psychiatric Hospital in relation to Queen Street and put them both against the most northwest tip of Peel, the distance between Queen Street and Lakeshore for someone travelling from that far up is not that great.

However, what role do we play, how are we going to play a role, how are we going to supply backup services, and what are we going to be called upon to do, are all questions which require preparation. That was our concern. I think that should be taken as the prevailing tone of the letter. It wasn't necessarily to criticize the decision itself but the need for our concerns and adequate planning to be undertaken.

**Mr. Lawlor:** In the newspaper article—this is perhaps my last question—you say, "In an interview last night the ministry simply looked to see whether Queen Street

had enough beds to take in the Lakeshore patients without worrying about treatment programs or staffing. 'The number of beds means little for active mental patients,' he said. 'They are just a place to sleep.'"

**Dr. Guirguis:** That's what the reporter said I said.

**Mr. Lawlor:** Yes.

**Dr. Guirguis:** I think that should be kept in mind. I don't usually talk to the press because of my position. I often like to get clearance first. It was better to try to clarify a point or two to the reporters than to let them make up their own minds, perhaps wrongly. The statement as it was made was made in reference to a question put to me by the reporter—"But there are beds there, aren't there?" or words to that effect. I had to explain to the reporter the significance of a bed, four walls, as opposed to a bed supplied with all the resources required to deliver the service. So it's slightly out of context.

**Mr. Lawlor:** I'll let somebody else follow.

**Mr. Chairman:** As you know, 15 minutes was allocated to each party and I am afraid the 15 minutes are up. If you wish to get back in again, provided Mr. Kennedy and Mr. Jones don't use all of their 15 minutes allocated, that would be perfectly acceptable. But I think, in view of the time constraints, I'll go to Mr. Kennedy, and Mr. Jones.

**Mr. Kennedy:** Thank you, Mr. Chairman, I just had a couple of questions and then would pass to Mr. Jones.

On May 2, doctor, Dr. Durost discussed the numbers of beds and the accommodation facilities and so on. I won't go into all the figures, but it ended up that it leaves 94 empty beds, which would be an 85 per cent occupancy rate. Also he didn't see any difficulty in dealing with patient load on the short term. Is that consistent with your views?

**Dr. Guirguis:** Perhaps that might be easily accommodated with a proper plan on the long term. On the short term in my colleagues' views it has, or it may have, since we don't have hard evidence, contributed to the present overcrowding situation. The structure in Queen Street requires the opening of full wards or half-wards; you don't have large enough units to accommodate more and more patients, say, with the same resources.

**Mr. Kennedy:** So a certain area could be overcrowded but with vacant beds in another part of the hospital?

**Dr. Guirguis:** Yes. We have—



**Mr. Kennedy:** Is this what you are saying really in your letter? So is there a consistency with what Dr. Durost said or not?

**Dr. Guirguis:** To the extent that the space is available, certainly. We can't dispute that the space is available.

**Mr. Kennedy:** Thank you. There is one other point. We were told Dr. Durost also said, "Queen Street has a program planning committee which is dealing with the on-going process of implementing, and planning for implementing, the move of patients from Lakeshore to Queen Street, and maintaining the outpatient services which are presently being provided by Lakeshore Psychiatric, and so on, until Dr. Lynes' committee reported." Are you a part of that program planning committee?

**Dr. Guirguis:** Yes, sir, I am.

**Mr. Kennedy:** How often do you meet and what has been the results of your meetings? Do you concur with that?

**Dr. Guirguis:** We are dealing with the situation, there's no question. There are a lot of problems arising; that also is so. But I have to repeat that this is also without, to our mind, an adequate plan.

**Mr. Kennedy:** But the committee is addressing itself to the plan, as is stated here. Is that correct?

**Dr. Guirguis:** Only to a certain extent.

**Mr. Kennedy:** Are you optimistic?

**Dr. Guirguis:** We are not in full control of what—we are planning only those areas in which we have involvement and concrete knowledge, and know where and what is the objective, and we sit and plan for it.

**Mr. Kennedy:** How long has the committee been going? Since the announcement?

**Dr. Guirguis:** Oh, yes. We used to meet, I think, in another context, but once the announcement was made, we have been meeting regularly on a weekly basis, sometimes a bit more frequently.

**Mr. Kennedy:** And Dr. Durost is on that committee too?

**Dr. Guirguis:** Yes. We haven't stopped trying to deal with the problem. From the minute we found out what's going to happen, we have tried to deal with it. But that doesn't prevent us from being concerned about long-term implications.

[4:00]

**Mr. Kennedy:** Having had those discussions, this letter expresses your concern?

**Dr. Guirguis:** Right.

**Mr. Kennedy:** Even though the committee's meeting, and this is what's surfaced in your mind?

**Dr. Guirguis:** Yes.

**Mr. Chairman:** Thank you, we'll pass to Mr. Jones now.

**Mr. Jones:** I'll be very brief, Mr. Chairman, and doctor. I'd just like a couple of points of clarification if I could. Do I understand you correctly to have said in reply to Mr. Lawlor that on your concern here—page two in the list B—the University of Toronto Teaching Hospital and your concern about the maintenance of the academic standards, that today you're saying to us that you're satisfied that those regulations are not imperilled?

**Dr. Guirguis:** Yes. You're right. We were told that.

**Mr. Jones:** Okay, so that is changed, for some reason, since you wrote this letter on behalf of yourself and colleagues?

**Dr. Guirguis:** Well—

**Mr. Jones:** Could you also just clarify another point for me? I know some of the members like to deal in history—Mr. Lawlor likes to deal a great deal in history, and as you were answering Mr. Kennedy, you referred to this period of February to mid-April, and that is I suppose recent history. I know we're concerned about the overcrowding you alluded to there, where you had the 68-bed unit. You've just confirmed that you had extra bed space, though.

**Dr. Guirguis:** Not on my service.

**Mr. Jones:** Not on your service? Within the hospital?

**Dr. Guirguis:** Oh, yes.

**Mr. Jones:** I think you went on to say here that there were pressures on other parts of the hospital, but they're less severe. Could you just clarify for us?

**Dr. Guirguis:** Yes, there was a period when two out of three geographical services—one was mine and the other one was Southeastern Service—were in a state of overcrowding. This compelled us to put patients in the empty spaces in the other service overnight. Since then, because of the efforts we've been exerting, that has somewhat diminished. There's still a measure of overcrowding, but we're dealing with it. This seems to be a seasonal phenomenon, but it has gone on a bit and we are wondering whether this has something to do with it.

**Mr. Jones:** You were saying in answer to Mr. Conway's earlier questions it concerned yourself and others of the staff that some of



the patients were having to leave the facility sooner than, I believe your words were "sooner than you would have liked to have seen." Is that in the context of that February-April time of—it would be the minister referred to in this article. That experience doesn't happen too often, or hasn't been experienced a great deal—the influx of new people? So are you saying that some had to leave earlier than you would have liked during that period, and perhaps Lakeshore played a role?

**Dr. Guirguis:** Yes.

**Mr. Jones:** The new patients?

**Dr. Guirguis:** Yes.

**Mr. Jones:** You're not necessarily casting a gloom situation for now and forward?

**Dr. Guirguis:** Well, we are concerned that if the matter is not dealt with and looked at as part of a preparation and adequate planning, in which we would have input, the situation could continue. As it is, there is still a measure of overcrowding in my service.

**Mr. Jones:** Did I understand you then, doctor, to say that out of your meeting this morning with ministry people, you feel you're going to have more involvement in the planning and greater awareness of—

**Dr. Guirguis:** Yes, sir, we were given that assurance.

**Mr. Jones:** I see. So may I ask the straight question then? Do you, with that planning and greater involvement in that planning and awareness, and given the fact, as you say, that those things you referred to in the letter did refer to February-April, and while you still have some pressures if you could do part of the planning processes to get the resources so the beds also have what else they need, would you still be in agreement with the closure, or would you be opposed to the closure of Lakeshore?

**Dr. Guirguis:** Well, speaking for the medical staff—

**Mr. Jones:** Relative to Queen Street.

**Dr. Guirguis:** Yes, I—

**Mr. Jones:** And I'm just saying, doctor, also relative to what we've heard in front of this committee, that other services will continue over there.

**Dr. Guirguis:** I'm saying we can accommodate work. I can't say—because I don't have the information that would permit me to say definitely—anything about the decision itself. In fact, we're rather anxious, as medical staff, not to appear to be addressing that as the issue but the question of what to do about it.

**Mr. Jones:** This will be my final question, doctor. This letter was intended to express your concerns during that period of pressure, that transition period, and until the full resources become available, the beds were there, and it wasn't intended to be in support of, or a protest against, the closing of Lakeshore. Is that a fair comment?

**Dr. Guirguis:** No, it was not intended to protest the closure.

**Mr. Jones:** I see, thank you.

**Mr. Dukszta:** Dr. Guirguis, your medical staff met when? What time last week?

**Mr. Chairman:** About two minutes, Dr. Dukszta.

**Mr. Dukszta:** Oh, then if I've two minutes, I'll ask a different question. Dr. Guirguis, I see you are maybe less concerned with an immediate plan, as the damage has already been done, than with what will happen if the two hospitals are coalesced into one. If we project, according to McKinsey, the input of patients, my concern is what will happen in the next five to 10 years if the two hospitals are combined into one large institution. Potentially then, using your statement that there has been a 34 per cent increase in admissions, and supposing that continues for the joint catchment areas of the hospital, we may expect a hospital with 800 to 900 beds. Do you agree with that?

**Dr. Guirguis:** We may expand to—

**Mr. Dukszta:** We may expect within five years, according to your figures, one hospital for that big catchment area, with about 800 to 900 beds?

**Dr. Guirguis:** Not necessarily, Dr. Dukszta. I think if we prepare properly and make some adequate plans on the basis of which we can make some predictions, and given our particular orientation to the community thrust in our psychiatric work, I can't say whether we are going to be an 800- or 900-bed hospital or remain as we are. I am simply anxious that we get involved and have input in what is going on so that we know what we are taking on.

**Mr. Dukszta:** Would you agree with the conclusion of McKinsey that we would have a large, large hospital if the two hospitals are coalesced? How many of those McKinsey conclusions do you agree with? Do you agree with most of them?

**Dr. Guirguis:** I can't remember all McKinsey's conclusions except the recommendation in relation to our increasing our catchment area and the modifications suggested for the other hospitals.

**Mr. Duktza:** Have you accepted then the recommended increase of your own catchment area and the modification for the other two hospitals? Do you believe that's one of the major recommendations of the McKinsey report?

**Dr. Guirguis:** I only said this is what McKinsey recommended.

**Mr. Duktza:** Yes, are you in agreement with that basically?

**Dr. Guirguis:** I haven't really considered that matter in relation to coalescing hospitals. We're really addressing the situation, as it were post-talk, now that it's been decided how we can best make it work.

**Mr. Duktza:** Was that question discussed at the meeting of the Medical Advisory Committee a couple of days ago?

**Dr. Guirguis:** The Medical Advisory Committee didn't discuss it, it was the medical staff who discussed it.

**Mr. Duktza:** Sorry, medical staff. That was discussed, was it? The question of coalescing the two hospitals which went directly against one of the recommendations of the McKinsey report.

**Dr. Guirguis:** Oh, yes, it was discussed. Not everybody on the medical staff could still remember or was familiar with all the recommendations of the McKinsey report, but some medical staff had indicated that what was happening now was not the recommendation.

**Mr. Duktza:** There was some expression of opinion by the medical staff that this is not what McKinsey recommended?

**Dr. Guirguis:** Some members did indicate that.

**Mr. Duktza:** But that seems to be directly stated in a statement which you presented on Friday, using the figures that the admission rate, continuing at the present rate of 34 per cent increase per year, would lead to a serious overcrowding which we'll get towards—at the bottom of page two.

**Dr. Guirguis:** Oh, no, this figure I'm quoting here has nothing to do with the McKinsey report at all.

**Mr. Duktza:** A 34 per cent increase in admission actually comes directly from—

**Dr. Guirguis:** From what is happening to us now.

**Mr. Duktza:** Oh, well, that's even worse, if it is happening to you right now. The McKinsey report suggests that this would happen to the Lakeshore catchment area, which with your own increase plus the Lakeshore in fact means a much higher

degree of overcrowding, a much greater need in beds than is already specified. We are in fact talking now of a hospital of 900 beds in 1985, which is only six years from now.

**Dr. Guirguis:** Who is to say?

**Mr. Duktza:** The McKinsey report basically says it—on which we have to rely, I agree. It's difficult for you to say that the only way we can judge on it is from a technical study done by the experts who say that if the present demographic trends continue—are you agreeing with this?

**Dr. Guirguis:** Yes.

**Mr. Duktza:** If the present demographic trends continue willy-nilly, we'll end up with a large hospital of 900 beds within six years.

**Mr. Chairman:** Dr. Duktza, I have to tell you that you've extended your time and then some. I'm sorry.

**Mr. Sweeney,** do you have a question?

**Mr. Sweeney:** No, I'll leave it.

**Mr. Conway:** I have just one very important point of clarification, if I may put it. I want to be clear on this letter. The Medical Advisory Committee sent this letter to the chairman of the standing committee on social development on Thursday, May 10. Prior to that did you direct any such letter or equivalent outlining these concerns to your superiors in the ministry?

**Dr. Guirguis:** Not in exactly those terms. But we have made several of our concerns known.

**Mr. Conway:** Now I want to be clear again. You were called yesterday by whom to meet with whom this morning?

**Dr. Guirguis:** I was called by the medical director and informed that there would be a meeting this morning.

**Mr. Conway:** You were called by the medical director at Queen Street?

**Dr. Guirguis:** Yes.

**Mr. Conway:** Were you told what the meeting was going to be about and where?

**Dr. Guirguis:** I was told it was going to be to discuss our letter and that it would be in the Hepburn block.

**Mr. Conway:** I'm just interested to know how the chairman—you didn't hear from the chairman of the social development committee to whom the letter was sent? You heard rather from the Ministry of Health to whom a copy of the letter was not sent by you?

**Dr. Guirguis:** No, we sent a copy to the administrator.



**Mr. Conway:** So they had a copy. At the meeting this morning with the medical director, the meeting was held where?

**Dr. Guirguis:** In the Hepburn block.

**Mr. Conway:** In the Hepburn block, and who was there in addition to the—

**Dr. Guirguis:** There were a number of gentlemen there, in addition to about seven of us from the medical staff, and there was Dr. Dyer, and Mr. Campbell and Mr. Teasdale and Mr. Jappy and some other people; I don't recall the names.

**Mr. Conway:** Thank you.

**Mr. Chairman:** Mr. O'Neil, you have one short question. Dr. Guirguis has to go. He indicated that he would like to get away at four o'clock and I think we should respect that time limit.

**Mr. O'Neil:** Would you say that there was any undue pressure put upon you this morning at that meeting to help you change your mind in the views that you had expressed in this letter that was sent out on May 10?

**Dr. Guirguis:** No, no undue pressure. There was an indication that they were very concerned about our concerns and they would like to—

**Mrs. Campbell:** Start talking.

**Dr. Guirguis:** Talk about them and take them into consideration. I thought that was precisely what we intended and hoped would happen.

**Mr. Conway:** They didn't respond that way to your earlier communication?

**Dr. Guirguis:** No, they didn't.

**Mr. Conway:** When was that earlier communication, can you remember?

**Dr. Guirguis:** The communications have been going through the usual channels, through the medical director, through the administrator, through the different committees in the hospital, expressing various concerns.

**Mr. Conway:** But this was the first one that really seemed to elicit a wholesome response from the Ministry of Health.

**Mr. R. F. Johnston:** Incorrectly addressed as well.  
[4:15]

**Mr. Kennedy:** Just one final question, since we are all having final questions. You did take these concerns up with the Queen Street planning committee from time to time, but not as a package?

**Dr. Guirguis:** Yes, that is correct.

**Mr. Kennedy:** Is it still on the agenda for further discussion?

**Dr. Guirguis:** Yes. We discuss different aspects as they become more critical and more pressing. Occasionally we have to stop looking at other things because one particular issue or another has to be dealt with immediately, and that is also one of our concerns.

**Mr. Chairman:** Thank you very much, Dr. Guirguis, for your time. I know it has been inconvenient for you but we do appreciate your coming here and clarifying the points raised in your letter.

**Mrs. Campbell:** Whether you like it or not, that was a political letter.

**Mr. Chairman:** I am not sure that will make Dr. Guirguis feel any better.

**Dr. Guirguis:** That wasn't our intention. I have to reassert that.

**Mrs. Campbell:** Too bad you didn't mean partisan. If you breathe you are political.

**Dr. Guirguis:** I have been asked by the medical staff to indicate that wasn't our intention.

**Mr. Chairman:** Our next witnesses are the minister, Mr. Timbrell, Dr. Lynes and Mr. Jappy.

**Hon. Mr. Timbrell:** The committee is concluding what have been three rather full weeks of testimony, discussion, and cross-examination of a variety of people who have an interest in the question of the movement of the inpatient population from Lakeshore Psychiatric Hospital to Queen Street Mental Health Centre, the maintenance of the existing outpatient programs, and the question of expansion into other endeavours, additional community mental health programs.

As I said in the House and as I said on April 23, you have heard a wide range of views from people with equally eminent qualifications, so I suppose we would have to say literally no stone has been left unturned in terms of exposing philosophies and approaches.

To answer questions and assist in responding to some points that have been raised I have with me today. Mr. Jappy, who is the director of the psychiatric hospitals branch, and Dr. Lynes, who is the principal program adviser on matters of mental health. I have also asked Mr. Fisher, the administrator at Queen Street, and Dr. Durost, the medical director of Queen Street, to sit in this afternoon to answer any questions you may have over and above those which you put to them when they appeared here in the last couple of weeks.

I would like to go through some notes I made drawing from the testimony you heard and dealing with certain themes. The first has



to do with the question of the Lakeshore facility itself.

As you know, going back to January, I indicated there were a number of factors that led to the decision of cabinet to close Lakeshore. One of them certainly was the question of the condition of the buildings as described in a variety of reports, including the McKinsey report itself.

**Mr. Lawlor:** Is it still a firetrap?

**Hon. Mr. Timbrell:** I think if you look at the McKinsey report they make the point—I am not sure of the page number, I think it is page three; it is right up front anyway—where they say—

**Mr. Duksza:** You're not sure.

**Hon. Mr. Timbrell:** Well, I've said to you from the beginning, if you are going to have McKinsey as your Bible you would have to have the new testament and the old.

**Mr. Duksza:** That applies to both of us, Mr. Timbrell.

**Hon. Mr. Timbrell:** In fact, right up front, they say that fires are an ever-present danger. Of course there is also the report of May 1978 from Mr. Manson, and you have this as well, which indicated the need for certain fire safety improvements and in his report he said, "... which may be necessary to ensure at least a minimum safety to life."

The fact of the matter is, as McKinsey says, these are outdated facilities. One of the factors leading from that, and in the decision, was that we are advised capital dollars are not available to replace both Whitby and Lakeshore. Second, of course, is the question of the availability at Queen Street of facilities for the inpatient population. More on that in a few moments.

In several submissions there were varying figures and estimates presented to you with regard to actual expenditures for renovations and these figures went as high, I believe, as \$2.5 million. I asked the staff to check over the last six years and other than capital spending for the new industrial and trades building which cost \$823,800, the Ministry of Government Services has spent \$1,052,000 on a variety of small items.

There have been questions raised with regard to the question of the ownership of the site. I want to reiterate what I said on April 23—that cabinet decided the site will remain in public ownership. When that decision was made I communicated it immediately to the mayor of Etobicoke and to the chairman of Metro—both Tories, Mrs. Campbell—inasmuch as the borough of Etobicoke and Metro government had over the years indicated interest in some aspects of the site. In fact, I am

told, a few years ago it was indicated that we were prepared to talk with other public bodies like Metro or Etobicoke and I reiterated that the land would stay in public ownership.

Apparently at one time there was an interest on the part of Metro, and Mr. Lawlor will recall this because I think at one time or another he has proposed senior citizen housing on one corner. I specifically indicated if at some time in the future Metro were interested in that sort of thing, we would be prepared to enter into discussions with them about that.

In the case of Etobicoke I understand there has been some interest shown from time to time in the question of extending Kipling Avenue down to the planned marine development. Again I indicated to the mayor of Etobicoke that if that interest arose again in the future we'd be prepared to discuss it, but the fact of the matter is the land will remain in public ownership.

At various points along the way, Mr. Chairman, there were points of view expressed—in fact I guess this was something that was under discussion the last time I was here—about the ideal size of a psychiatric facility. A lot of reference was again made to the McKinsey report. The opening of the beds at Queen Street will raise it to a 632-bed psychiatric facility to which must be added the 68 beds which are being used for the forensic unit, METFORS. Now this compares to other psychiatric facilities such as Whitby, which is currently rated at 500 beds, London Psychiatric which is rated at 544 beds, and Brockville Psychiatric, which is rated at 529 beds. So it's in the same range as a number of other very successful psychiatric facilities. In fact, of those three, two are also associated with medical faculties—London to the University of Western Ontario, and Brockville to Ottawa.

**Mr. McClellan:** Whitby is successful?

**Hon. Mr. Timbrell:** Well, Whitby has run some very successful programs. I think with the new facility built in the 1980s it will go a long way to assisting in the continued development of your program there. I'm sure you've visited Whitby. The total site is something of the order of 400 acres. Being spread as it is, among all those cottages, there are difficulties even in getting food and services around, quite an impossible kind of situation, and one which certainly wouldn't be repeated today.

**Mr. McClellan:** "Impossible," "successful."

**Hon. Mr. Timbrell:** The other point: Over the course of the last three weeks you've

been exposed again, as I predicted you would be, to various philosophies about mental health care and projections. I wanted to take a minute to look back. It may give us some yardstick for the future.

The fact of the matter is that in Ontario, as in most jurisdictions in the free world at least, the use of psychiatric—

Excuse me, may I have a five-minute break, Mr. Chairman? Something has come up.

**Mr. Chairman:** Agreed.

The committee recessed at 4:27 p.m. and resumed at 4:50 p.m.

On resumption:

**Mr. Chairman:** Order. We will reconvene. Mr. Lawlor, you have a point.

**Mr. Lawlor:** Now the minister, on the five-minute recess, knows in a fairly direct way what it means to be cut off.

**Hon. Mr. Timbrell:** That's not in any way determined at this point. That's why it became 15 minutes.

**Mr. Lawlor:** I hope other things aren't determined either.

**Hon. Mr. Timbrell:** No.

**Mr. Conway:** Mr. Minister, you don't wish to avail yourself, in the committee, of the opportunity to make any statements, tentative or otherwise, about the nature of federal-provincial relations and health-care policy?

**Hon. Mr. Timbrell:** No, but I do understand that last night there was a full moon.

**Mr. Sweeney:** Is that the excuse Joe is going to use?

**Hon. Mr. Timbrell:** No, but it might explain the report I got which may be confirmed a little later about a press conference at the Sheraton.

**Mr. Lawlor:** Will it affect you?

**Hon. Mr. Timbrell:** No.

**Mr. Chairman:** Order. Perhaps we can get on with the minister's statement. I don't think we'll resolve these federal-provincial matters in the next five minutes.

**Hon. Mr. Timbrell:** No, maybe 10.

**Mr. Kennedy:** We can solve them in 30 seconds.

**Hon. Mr. Timbrell:** Earlier on I was getting into the question of the matter of philosophies, and obviously most of us in the province are not professionals in this field, so we are at both a disadvantage and an advantage, inasmuch as we have to apply our own principles and make our own kind of judgments of what is appropriate.

This is not unlike what we were doing not quite a year ago now in reviewing Bill 19, which amended the Mental Health Act.

For the interest of many members of the committee who were here then, the Manitoba Law Reform Commission has just reported in the last couple of weeks and recommended that Ontario model for Manitoba.

**Mr. Conway:** Under the new government, I understand. They are making their way through the 19th century.

**Hon. Mr. Timbrell:** Well, this law reform commission has been in operation since the middle of the 20th, and has just reported this to the government and people of Manitoba. That is tangential to this matter. But I thought you would be interested. I will get you a copy if you are interested that much.

**Mrs. Campbell:** He is a great historian. He would be interested in historical—

**Hon. Mr. Timbrell:** There are no bad historians, no bad historians.

**Mr. Conway:** Joe Clark is not a good one.

**Mrs. Campbell:** No.

**Hon. Mr. Timbrell:** Mr. Chairman, I would be relieved if you would keep order.

**Mr. Chairman:** Order, order.

**Mr. Sweeney:** The interjections by the minister are causing all the problem.

**Hon. Mr. Timbrell:** As the members will recall from the discussions which have gone on over the last three weeks and going back to a year ago when we discussed Bill 19 in the House and here, there have been tremendous changes in the delivery of psychiatric care, or mental health care, in the last decade. Certainly there have been an awful lot of changes since the end of the war—my own father worked as a psychiatric attendant at Kingston Psychiatric Hospital.

Inasmuch as the inpatient population of our psychiatric facilities has declined markedly in the last 10 to 15 years, and certainly as compared to say 25 or 30 years ago, we have seen a significant growth in the number of psychiatric units in public community hospitals and a significant growth in the number of community mental health activities, through a variety of community organizations, such as Mental Health Ontario and its many, many affiliates around the province.

**Mrs. Campbell:** Unfortunately, not in Metro.

**Mr. Chairman:** Order.

**Hon. Mr. Timbrell:** Well, we can come to Metro. There have been quite a number of things happening in Metro lately.

Again, to those who are absolute and total devotees of McKinsey, they do point



out that this tertiary role of the provincial psychiatric hospital in relation to the secondary role of the community hospital where we have—how many now?

**Mr. Jappy:** About 56.

**Hon. Mr. Timbrell:** About 56 units and a couple of thousand beds, I guess.

**Mr. Jappy:** Over 2,000.

**Hon. Mr. Timbrell:** Over 2,000 beds in community psychiatric units, and the primary role of the physician, of course, the psychiatrist in his community practice and the community mental health programs, is aimed at assisting the individual in need in the community, either in a preventive or restorative role.

This has come, of course, at a time, particularly in the last decade—you have had the figures given to you several times—of declines in inpatient population of the psychiatric hospitals in and around Metropolitan Toronto, while the population has increased markedly in their catchment areas. In looking ahead to the future, I think it is fair to project that Queen Street will be able to handle the tertiary care needs of the enlarged catchment area, part of the Lakeshore catchment area having gone to Hamilton Psychiatric Hospital and other parts having gone to Whitby Psychiatric Hospital, and aided all the while by the development of more outpatient or community mental health programs in the former Lakeshore catchment area. We will get to that in a little while, because it seems to me that program submissions such as we have had, proposing crisis intervention and co-ordination in the various communities, will go a long way to ensuring that we do in fact treat people according to their needs at the primary, secondary and tertiary levels in the system. [5:00]

I think, in short, I think we need to bear in mind the progress that has been made in the field of psychiatry. Again, any observations I make are obviously those of a layman, but an interested layman, in the whole area of mental health and psychiatric services. Looking ahead to the future, the concern is that we not revert, that we not go back to a heavier than necessary emphasis on institutional care.

Now, concern has been expressed on several occasions, Mr. Chairman, with regard to patient transfers. At this point, of course, there have been no transfers since April sometime?

**Mr. Jappy:** I am sorry, I don't remember the date.

**Hon. Mr. Timbrell:** Do you recall?

**Dr. Durost:** April 4, I believe.

**Hon. Mr. Timbrell:** April 4, doctor? And there are no plans to transfer anyone before May 30?

**Dr. Durost:** May 30.

**Hon. Mr. Timbrell:** May 30, and that has been put back several times so as to allow sufficient time to prepare for these patients.

I am advised that as of May 10 there are 121 psychiatric inpatients who are expected to transfer. This would leave Queen Street, when all is said and done, with approximately 60 beds at this point and 100 further on.

**Mr. Lawlor:** That includes the difficult beds?

**Hon. Mr. Timbrell:** Yes, that's right.

**Mr. Lawlor:** It is getting more difficult.

**Hon. Mr. Timbrell:** Nobody ever tried to pretend that this was a simple or easy exercise, and we are trying not to make it any more difficult.

**Mr. McClellan:** When did it go down to 121 patients to be transferred?

**Hon. Mr. Timbrell:** I suggest we save those until the end because Dr. Durost is here, and Mr. Fisher. We're tracing the numbers.

At any rate, I think this demonstrates that all of the inpatients can be accommodated. I think this was acknowledged by all of the witnesses who appeared from Queen Street, and we will have a chance to discuss this. I certainly appreciate the concerns expressed by a number about involvement in planning, about ensuring that we are in fact not rushing this.

I would remind you again, when I made the announcement in January and when I met with you last on April 23, I had indicated that when the decision was made to close, we really had two options. It could have been done in the space of a couple of months and satisfied the provisions of the labour statutes in terms of notices, or it could be done in eight months, to allow what we felt was sufficient time to involve community and professionals in looking at the existing outpatient programs, new community mental health programs, and making the necessary provision over that time to move the inpatient population.

Now, there has been concern expressed again with regard to the matter of admission policies. That's another reason I asked Mr. Fisher and Dr. Durost to be here today, to continue, if you wish, the discussion you had with them before about this question.

This matter is being addressed by an inter-hospital committee. It has members drawn from the Queen Street Mental Health Centre,



from Etobicoke General Hospital, from North-western General Hospital, York-Finch General Hospital, Humber Memorial Hospital, and our own psychiatric hospitals branch, in order to delve into this area. It's not a simple area, inasmuch as there is an overlap between the role of the psychiatric unit in the community hospital, the secondary unit, as it were, and those involved in the provision of tertiary care in the provincial psychiatric hospitals.

We recognize, whether it's in a case like this involving the merger of two inpatient programs, or in cases where you might have a change in medical directors, and perhaps, a change in philosophy, that the only way this is going to work properly is through co-ordination and co-operation among those who are involved at the secondary and tertiary levels to bring about effective planning.

One of the things that concerned me, and I think I know who raised the question, although it doesn't really matter, but there was a statement made by a psychiatric professional about Queen Street, indicating he felt there were some problems there because it is a teaching hospital. My impression, and certainly the impression of those in the ministry whose opinions I seek on such matters, is that the association has been a good one for Queen Street in the advances they have been able to make over the last number of years.

Teaching associations have been beneficial in a number of our hospitals. That is not to say—and I want to make this point—that the programs in those hospitals which are not teaching affiliated are in some way substandard or second class.

It has concerned me to have reports come back to me privately that some of the medical staff at Lakeshore Psychiatric Hospital feel that I, the ministry, haven't recognized the quality of the programs there. I want to put that out of their minds. I have never questioned the abilities of our staff at Lakeshore. I have publicly lauded them in the past. That was confirmed in the most recent creditation report. It seems to me that the decision taken is trying to build on that with better facilities and better and more programs in the community, not to tear it down. No one should feel that we're still somehow trying to call into doubt their professional competence or place it under some kind of a cloud.

As I mentioned earlier, we have a number of other hospitals in the province which are associated with medical schools, in effect as teaching facilities: London Psychiatric Hospital, Hamilton Psychiatric Hospital, Brockville, Kingston and North Bay.

There was also interest and concern expressed regarding the psychogeriatric pro-

grams and the result of the transfer in early April of those patients.

Queen Street is acknowledged to be one of the best as well as one of the largest psychogeriatric programs in the country. As you know, a number of pieces of research have been done through that psychogeriatric unit which have been published over the years, including one study in particular that was of interest at the time of the transfer. That I think was authored by Dr. Durost. It's on the question of the effect of change on psychogeriatric patients.

**Dr. Durost:** No. I believe that was Dr. Radmanather—I am sorry I can't remember. He was a resident there for a year.

**Hon. Mr. Timbrell:** Okay. All right. There was an interest at that time in the change because of the activities that surrounded or accompanied the movement of the patients. I think you have also had the benefit of having before you and chatting with the lady who is—I think she's the head nurse, Mrs. Latimer?—

**Mr. Jappy:** Director of nursing.

**Hon. Mr. Timbrell:**—director of nursing of the psychogeriatric unit, who has commented to you on the change in the surroundings, the way the elderly patients settled in, and the effect the program and the more modern surroundings had on them. I understand, and I think this is totally universal, the concern about the effect of any move on elderly patients. The point was also made that even a reorganization of a unit can have a traumatic effect, just changing people around them, which any of us who have served on the boards of homes for the aged can attest to in our dealings with such facilities. I haven't had a chance to talk to any of the members of the committee, other than members of my own party, since they toured the two facilities but I am sure you noticed a marked contrast.

**Mrs. Campbell:** We toured the two facilities?

**Hon. Mr. Timbrell:** My understanding is most members at one point or another, either during the process of this committee or at some point, have toured both.

**Mrs. Campbell:** And a great tour it was.

**Hon. Mr. Timbrell:** There is a question of staffing standards. Again I want to remind the committee that over the years the inpatient population in our provincial psychiatric facilities has been dropping and the number and overall size of community psychiatric units and community mental health programs have been increasing. The staff to

patient ratios in the psychiatric hospitals have been steadily improving. Queen Street is perhaps a good example to put on the record. In 1970 there was a 1.25 staff to patient ratio and in 1978, that ratio was 2.71. Now, Queen Street has one of the highest staff to patient ratios of any of our facilities.

One thing that concerned me was a report entitled, The Mayor's Task Force on Mental Health, and I guess this would be the one from Toronto. The MOH from Toronto—

**Mr. Lawlor:** The MOH from Etobicoke.

**Hon. Mr. Timbrell:** Was it Etobicoke? Sorry, I beg your pardon. It indicated that concern about Queen Street reverting to a facility of 900 or more beds. I don't know where that gentleman got that notion. At one time it was even larger than that, in its previous incarnation, but certainly its maximum capacity now including METFORS is 700—632 without METFORS.

**Mrs. Campbell:** Freudian slip.

**Hon. Mr. Timbrell:** The other point of course I want to make is that Queen Street isn't getting the entire catchment area of Lakeshore. Part has gone to Hamilton and part has gone to Whitby, so that has to be borne in mind as well.

[5:15]

Many have endorsed the concept of community psychiatry. Yet there have been concerns, and I think legitimate concerns, expressed about the continuity of existing outpatient services and about planning and co-ordination and effective communication networks of same for the future for community mental health.

I want to reiterate, and this is something that keeps getting obscured, for whatever reason: none of the existing outpatient programs is going to be disbanded. In fact, as I indicated to you on April 23, there is, in effect, a moratorium on any measures to move any of the existing outpatient programs from the Lakeshore site until such time as we have had a chance to complete the review of the recommendations we have received, which include recommendations that some or all of those existing outpatient programs remain at Lakeshore.

Let me put it this way: The understanding which comes through in some quarters—when I have talked to people around Etobicoke, Mississauga, and so forth—is that somehow the existing outpatient programs are going to disappear and that in their place there will be this \$1.3 million for new community mental health programs. What I want to make clear is the existing

outpatient programs—I am thinking of the alcohol unit, DARE, the occupational therapy unit and so forth—will not be disbanded. They will be retained until such time as we have completed the review of the recommendations from the community committees, specifically and particularly Etobicoke, about where they should be located. Some of the recommendations have been that some or all of those existing outpatient programs stay at the Lakeshore site. Until that review is completed none of them is going to move anywhere.

**Mr. McClellan:** But the head of occupational therapy has been fired. You told me that when we were on tour at Lakeshore.

**Hon. Mr. Timbrell:** Can we come back to that?

**Mr. McClellan:** You are making statements that don't jibe with my understanding of what has happened. I understood that unit had been disbanded and there was a plan to move it to Queen Street. If you are announcing changes in the original scheduling or plan, I wish you would make them clear and not just try to fudge and blur everything that is going on there.

**Hon. Mr. Timbrell:** I understand from Mr. Jappy, and he can speak for himself, that he had spoken with the lady in charge and had indicated that as a result of the recommendations received there was a possibility that a decision would be made to retain that program on site. So what I am saying is totally consistent, I think.

**Mr. Jappy:** A lot of these people are looking for jobs.

**Mr. McClellan:** Because they had been laid off.

**Mr. Jappy:** Yes. And I think I told the same thing to the director of the industrial therapy unit. That is the one that Mr. Lawlor, when he toured the other day, asked about. He asked, "What is happening to this?" I said there had been indications from the community that this one should probably remain in this particular area since it was providing a service to inpatient and outpatient. When I knew these people were actively seeking positions and there was a possibility of them staying there, then naturally it behove me to tell the people. I think I was trying to be fair to the people.

**Hon. Mr. Timbrell:** When you used the term "fired," you meant this was an individual who had received one of the layoff notices of an earlier date.

**Mr. Jappy:** Yes.

**Mr. McClellan:** The unit was being moved.



**Mr. Duksza:** Fired, laid-off, it's the same thing.

**Mr. Chairman:** Please let the minister finish his statement.

**Mr. McClellan:** I wish you would try to deal a little more specifically and a little more precisely with the problems that have been identified to date, rather than just give us categorical assurance. We had evidence of problems.

**Hon. Mr. Timbrell:** I will try and, if not, then certainly I will be glad to answer your questions.

**Mr. McClellan:** I don't want to interrupt you, but I also want to understand what is happening there.

**Hon. Mr. Timbrell:** I am trying to respond to the themes. If I am not specific enough then certainly at the end I will be glad to try and answer anything you want.

**Mr. McClellan.** Thank you.

**Hon. Mr. Timbrell:** This has concerned me because in correspondence to me from people in the area, and in conversations I have had with people in the area, certainly they have been labouring under the misapprehension that this \$1.3 million, which has been earmarked for additional community health programs, is all it was going to be; that everything that has existed by way of outpatient programs was going to be thrown to the wind, disbanded, use whatever term you want. That's not correct.

All of the existing outpatient programs will be retained. All of them will stay exactly where they are right now, until such time as we have completed this review of the community recommendations, which includes recommendations to the effect that some of those programs should stay at Lakeshore.

The annual cost associated with operating those existing outpatient programs is \$1.6 million. Over and above that will be the \$1.3 million which has been allocated for additional community mental health programs.

You will know we have received quite a list of proposals, a number of which I am pleased to see in Mississauga and North York—two that come to mind—deal with the question of effective co-ordination in the community programs.

I served for a number of years in my earlier role as an alderman and a back-bench member on committees like the committee of Metro council on drug abuse and the inter-agency council of the borough of North York and I fully appreciate that they can, particularly from my experience on the inter-agency council of North York, bring about

a high level of co-ordination that simply can't really be matched by bureaucracies or government. I know Mrs. Campbell has had a lot of experience with this sort of thing as well.

Excuse me please. Just a minute, Mr. Chairman.

**Mr. Conway:** Not another dispatch from the campaign?

**Hon. Mr. Timbrell:** It has a pink note attached to it too.

**Mr. Sweeney:** It's usually a rejection slip.

**Hon. Mr. Timbrell:** There must have been two full moons. Elections do funny things to people.

**Mr. Conway:** We can get Otto Jelinek as Minister of Health.

**Mrs. Campbell:** That will be the frosty Friday.

**Hon. Mr. Timbrell:** To continue, Mr. Chairman, I am pleased to see these kind of submissions along with things like, let me see, I think it's Mississauga General that's made a submission to use some of the savings associated with the closing out of the inpatient programs for crisis intervention and they, of course, have a community psychiatric unit in their—well, I don't know why anyone would laugh at that. Crisis intervention units have proven to be quite successful and helpful.

Interjection.

**Hon. Mr. Timbrell:** Just to finish that point. While the inpatient population of the psychiatric hospitals has been declining, the growth of outpatient population has of course been almost logarithmic during the same period.

**Mr. McClellan:** To say nothing of readmissions.

**Hon. Mr. Timbrell:** Well, let's say something about readmissions.

**Mr. McClellan:** A good idea.

**Hon. Mr. Timbrell:** It's interesting to watch some people who would in one forum suggest we should not incarcerate people for long periods of time, that we should in fact have the psychiatric facility there as a backup for people, so that with the use of modern chemotherapy and other techniques they can be reinforced from time to time as needed, and then, for another purpose, try and label that as something which is bad.

**Mr. R. F. Johnston:** No, we're just saying it adds to the load.

**Hon. Mr. Timbrell:** It certainly increases the admission rate in that you have more people coming through for shorter periods of



time. There was a time when the average length of stay in a provincial psychiatric hospital was, I'm told, literally measured in years—or certainly many months, if not years.

We all remember, I'm sure, the stories of people who, after the 1967 amendments and the introduction of the review boards, were so to speak freed; people who had been there for extremely long periods of time. The average length of stay now in the psychiatric hospitals is—I think I'm correct—42 days, six weeks. Yes, the number of admissions is much higher, but the number of beds needed to accommodate that much higher rate of admission is significantly lower, inasmuch as they are staying for much shorter periods of time.

That's not something I'm ashamed of, or that anybody associated with any of the psychiatric facilities should be ashamed of. It's one other piece of evidence of the progress that has been made in our facilities in this province.

There have been concerns expressed about the matter of approved homes and housing. In particular, a concern was expressed here by a couple of members of the city of Toronto council about the Parkdale area. I guess there are a couple of points I should raise.

First of all, I am concerned that the mayor's task force report that was prepared for the mayor of Etobicoke, while it covered a lot of areas did not touch on the question of approved group homes in that community.

**Mrs. Campbell:** When can that be expected in Etobicoke?

**Hon. Mr. Timbrell:** You will know that progress is being made, albeit slowly. A couple of Saturdays ago, I happened to be in the Weston area and talking with a member of the York planning board. I was pleased to find out that York is considering—or has passed?

**Mr. Jappy:** It's very close to being passed.

**Hon. Mr. Timbrell:** —a bylaw that deals with the question of group homes.

**Mr. R. F. Johnston:** That wasn't the case when you made the decision though. What are you trying to say?

**Hon. Mr. Timbrell:** Let me finish, please.

**Mr. Chairman:** Order.

**Hon. Mr. Timbrell:** Even before the question arose of closing Lakeshore Psychiatric Hospital as an inpatient facility, there were some psychiatric patients requiring housing who tended to congregate in Parkdale because of the lack of similar planning in the municipalities within Lakeshore's catchment area. It's unfortunate that issue wasn't ad-

ressed in the mayor's task force report, and I would hope that, notwithstanding its not being included in that report, the members of the council of that borough and the planning board will deal with it. It has to be come to grips with some day, Mrs. Campbell. It's something I fought for when I was a member of our council in North York, not successfully, unfortunately.

**Mrs. Campbell:** And I, successfully.

**Hon. Mr. Timbrell:** You had more success than I had. It's something which is going to have to come. I fought long and hard in my own riding for a group home for the retarded. Like everyone else around this table who has fought for that kind of a project, it cost me a lot of support, but it's no less right because of that.

I'm told that a very small percentage of patients require housing. This figure comes from Mr. Fisher, so he can confirm or deny it, but I'm told that it's something in the nature of 20 per cent.

**Mr. Fisher:** That's correct.

**Hon. Mr. Timbrell:** That's essentially correct.

Basically, what we have here is a twofold matter. One is a matter of municipal planning. Certainly we, with our sister ministries of Community and Social Services and so forth, particularly through Mr. Jappy, have been regularly attending the municipal council and planning board meetings of all the municipalities around Metro over the last few years, urging them to come to grips with this problem and not just leave it in the lap of the city of Toronto and, to some extent, the smaller boroughs like East York and York.

As well, on the broader question of boarding homes in general, this is a matter for which remedies are provided in the public Health Act, for municipal bylaws to be passed and applied.

[5:30]

**Mrs. Campbell:** What are your standards?

**Hon. Mr. Timbrell:** The fact of the matter is it does fall under municipal jurisdiction, and it's one that is best looked after at the local level, rather than more broadly.

**Mr. McClellan:** That's not true.

**Hon. Mr. Timbrell:** Mrs. Campbell was concerned about what she thought was a discrepancy between a letter I had sent her—

**Mrs. Campbell:** March 28, I think.

**Hon. Mr. Timbrell:** —on March 28 and something that was said earlier. Do you want to comment on that, Mr. Jappy? Are you familiar with that?

**Mr. Jappy:** Yes, I believe during Mr. Fisher's testimony he indicated Queen Street Mental Health Centre has a housing policy which they follow, and thereby do appreciate the fact they have some responsibility to find people homes. This is for a very small number of people. Now, the letter which I sent was—

**Mrs. Campbell:** It doesn't matter.

**Mr. Jappy:** —which I believe was sent to Mrs. Campbell indicated that we at Health didn't feel responsible for the total housing program nor should we be setting the standards for it, although our hospitals, individually, have shown some obvious interest and concern in this area. But does that mean that we have to take on the mandate for the boarding-home policies, and so on, which are occupied by many people other than former psychiatric patients?

**Mrs. Campbell:** The letter is on file and it states categorically that none of the three psychiatric facilities recommends this area, the area being really south Parkdale; King Street, Dunn Avenue, and Beaty were all part of that inquiry. The answer specifically says that none of these institutions recommend—Mr. Fisher said, "Indeed, they feel a responsibility."

**Mr. Jappy:** On a point of clarification, I think the letter said that none of these facilities recommend these particular three homes which were under the microscope at that time.

**Mrs. Campbell:** No.

**Hon. Mr. Timbrell:** Would they get the letter and—

**Mrs. Campbell:** Yes, take a look at it.

**Hon. Mr. Timbrell:** All right.

**Mr. Conway:** On a point of order: I don't want to unduly pursue this, but by my reading of the clock we have 33 minutes until the normal time of adjournment. The steering committee did meet today and we were discussing the progress of the final few days of this particular reference. I don't know what the committee desires and I don't want to suggest to the minister that he should lessen his answers. I certainly appreciate the depth with which he is pursuing these matters. But I wonder what the committee's desire is, because it is my impression that there will be a number of members wanting to ask a substantial number of questions of the minister and I assume there is an obvious requirement for these people to return tomorrow. I don't know whether they are

operating under that assumption. If they are not, we had better get that cleared now.

**Hon. Mr. Timbrell:** I will try to be as brief as I can, Mr. Chairman.

**Mr. Duktza:** Mr. Minister, you don't need to be brief. I think you should continue. Each member here may have from 15 minutes to three-quarters of an hour of questioning of you afterwards. We could not accomplish this even if you applied your proverbial brevity.

**Hon. Mr. Timbrell:** I am always brief, you know that.

**Mr. Conway:** I just want to point that out to members so that we are aware—

**Mr. Duktza:** Mr. Chairman, in fact, we are addressing ourselves to you.

**Mr. Chairman:** It is pretty obvious that members will have some questions following the minister's comments and whether it is tomorrow or whenever. When you return, Mr. Minister, along with your people, is at your convenience.

**Mr. Conway:** Perhaps at this point I should just take advantage to indicate it was just generally agreed by the steering committee this morning that we would try to have the outline of a report ready for the chairman by Wednesday to introduce to the House. We don't need to stand by that, it was just a general understanding.

**Mr. Duktza:** The difficulty is that "by Wednesday." We will finish all the questioning tomorrow. When do we write it? And then we have to meet to discuss it.

**Mr. Conway:** I just thought I would indicate that was the steering committee's general understanding this morning. It is not firm or written in cement, but it was just what it was agreed as.

**Mr. Chairman:** Perhaps the minister could complete his comments and then, as we approach the adjournment hour, perhaps we can sort out the matter which Mr. Conway raised. We can deal with that, sort it out and arrive at some definitive plan for the next two or three days.

**Hon. Mr. Timbrell:** I will try to be brief, but I want to point a few things out.

Many have expressed the view that the additional outpatient programs, over and above those that exist now, should be in place before the total closure of Lakeshore is effected.

First of all, I think some people making that comment were again under the impression, contrary to what I indicated April 23 and contrary to what I reiterated today, that the existing outpatient programs were being



disbanded. That is not the case. They will be continued.

The second thing is the planned closure does not appear to be negatively affecting the inpatient programs that have been transferred. We feel that the transfers should go ahead after the end of the month as planned. As far as the outpatient services are concerned, there is no negative effect there.

You have had concerns indicated to you in testimony from people such as the executive director of the Ontario Mental Health Association. After indicating support for the closure, he expressed the same kind of concerns I would have, and I think any reasonable person would have—that there be effective co-ordination of existing programs, as well as effecting new outpatient programs.

It was reported to me that since the announcement in January there has been a high level of co-operation in the community aiming at this kind of co-ordination. That wasn't there before. Now you can perhaps say necessity is sometimes the mother of invention, or use similar expressions, but it has brought about a significant improvement in the level of co-ordination of the community programs and in assessing the existing outpatient programs—where they should be located—and in reviewing proposals for additional outpatient programs to be created.

Questions have been raised by some members of the committee with regard to actual staff transfers. As of this date I am advised that 311 staff are expected to transfer. This number is made up of 255 clinical staff and 56 support staff. This does not include the medical staff; it is strictly clinical and support staff. Of course, this number changes as people accept positions other than those offered at Queen Street and also when such factors as bumping rights are applied.

Do you want to add anything to that?

**Mr. Jappy:** Only if some member of the committee would like clarification on it.

**Mr. Conway:** Can we do that now? I would like some clarification.

**Mr. Chairman:** I would prefer to stand that over, Mr. Conway.

**Mr. Sweeney:** Obviously there has to be another figure there. With 300 being transferred, what—

**Hon. Mr. Timbrell:** And the number, subject to layoff notice now stands at—we will get you that. That again keeps going down because as people accept other positions and as positions are bumped, it has an effect both ways.

**Mr. Sweeney:** Give me a round figure.

**Mr. Jappy:** The layoff figure I understand is now reduced to 170 from 240 approximately originally.

**Hon. Mr. Timbrell:** I remember the last time I asked you was in my office. Your figure was 130 or something like that, because that 170 includes the bargaining unit and the management, so your number was around 130, I think, as I recall.

**Mr. Jappy:** I think they also indicated during their presentation the other day that approximately 100 people had been placed; is that correct, sir?

**Hon. Mr. Timbrell:** Yes. One thing that did concern me is that I read in one day's testimony—I am sorry, I can't recall which day so I can't read it verbatim—but there were two gentlemen here, Mr. Suttis and Mr. Barnes, who indicated—again, if I remember correctly—that they hadn't been interviewed, that nothing was being done. I want Mr. Jappy to perhaps take a minute to respond to that and to expand on what in fact has been done once, in February, the lists of redundant positions had been finalized.

**Mr. Jappy:** Yes. We knew we were facing a very large task and we formed a committee with five members, I believe, from OPSEU, two of whom I believe are here, Mr. Woods and Mrs. Paksi, and five members from the ministry, and we developed the seniority lists of those people who would be laid off and those people who would be transferred. We have continued to meet on at least a bi-weekly basis and we have interviewed all the staff who have received layoff notices, including Mr. Suttis and Mr. Barnes.

I imagine what they were implying was that up to this point in time they had not received a job offer, but they are certainly listed on the civil service redundancy list which is distributed to all the other ministries.

**Hon. Mr. Timbrell:** And on which we had considerable co-operation from the Civil Service Commission in identifying to the other ministries the categories in which there are people who, because of the move of Lakeshore, are in a redundant position, so as to require them to look first at our people if they have positions opening up in those categories.

There have been a number of changes over the years with the establishment of the district offices of OHIP and the like. Our record has been a very good one, when we have sufficient lead time to identify the redundant positions and then, with the assistance of the other ministries and particularly



the Civil Service Commission, try and steer these people towards vacancies.

**Mr. Sweeney:** Is that just within the provincial, or is it intergovernmental?

**Hon. Mr. Timbrell:** Well, again, do you want to cover the public hospitals side of it?

**Mr. Jappy:** Yes. What we also did was contact the administrator in each general hospital in the Toronto area and indicate that we had certain people on the layoff list. As a matter of fact, quite a few people have relocated in the general hospitals.

The layoff list is within the provincial government; it has not been distributed to other provincial governments.

**Hon. Mr. Timbrell:** Mr. Chairman, I just checked and I can come back tomorrow afternoon for an hour or so. I also have to leave as soon as I can to deal with that other matter that came up earlier in the afternoon, so I wonder if I could complete my response.

First of all, I will determine exactly what was said—

**Mr. Duksza:** An hour and 55 minutes or an hour and five minutes?

**Hon. Mr. Timbrell:** A couple of hours. I think there is some time there so I may move some things around and make myself available. I have ended up having to move a lot of meetings around, as you know, as the—

**Mr. Duksza:** We have no doubt that you have to do all sorts of things. If you didn't make that foolish decision then none of this would have happened.

**Hon. Mr. Timbrell:** I am more worried about not inconveniencing other people.

There has been a lot of discussion about the question of the alcohol program, and the question of the detox portion of it and the day-care portion of it. This is one I am perhaps a little more familiar with, inasmuch as through a mutual friend I met with the doctor in charge of that unit socially and made a point, on one of my visits to Lake-shore, to go through the unit.

This is an interesting aspect. I'm told something like 236 people have gone through the detoxification unit there in the last four months. Of those 236, nine elected to go on to the program. I think that is an interesting set of statistics. It makes me question whether in fact the two do indeed have to be contiguous, as between the detox unit and the day-care portion. But that is one which is under review, as I said earlier, based on the comments which have come from the community review committee.

Did you want to add anything to that?

[5:45]

**Mr. Jappy:** We had our own review done on the alcohol program since the detox unit being run contiguous to an elective program is inconsistent with what has happened in other areas of the province. It was the review committee's opinion that it didn't necessarily have to be there, and that the detox procedure could be carried out in the way that it's been carried out in three units in the Metro area and in the rest of the province. In other words, it can be located off campus.

What we usually do is tie them into a general hospital emergency department, so that if there is any emergent care required they can be looked after immediately and then returned to the detox centre. It really doesn't have to be part of a psychiatric hospital at all. But, once the individual is detoxified the referral portion is most important and they are offered the chance to go into this elective program that Dr. Maharaj is running or other elective programs which are available.

**Hon. Mr. Timbrell:** That internal review has been shared with Dr. Maharaj?

**Mr. Jappy:** Yes, it was.

**Mr. R. F. Johnston:** And he is in agreement?

**Mr. Jappy:** Yes, I talked to Dr. Maharaj—I believe it was a week ago—and he can certainly see our viewpoint on it. His concern was that he doesn't care where they're detoxified as long as—

**Mrs. Campbell:** As long they are.

**Mr. Jappy:** Right—and as long as the referrals are appropriately made so that he can get a chance.

Most of the recruits, if we can term them that, for his elective program come from direct company referrals. It's been very successful in that respect.

**Mr. R. F. Johnston:** On our tour he indicated to me personally that he very strongly wished them to stay together. I'm surprised that that seems to be at odds with that.

**Mr. Chairman:** Could the minister continue and wrap up?

**Hon. Mr. Timbrell:** Mr. Chairman, to wrap up then, I will come back tomorrow and answer all the questions I can.

I think it's worth again reiterating—sorry, there's one other thing.

**Mr. Conway:** Have you got a comment on children's services?

**Hon. Mr. Timbrell:** Yes. In the case of the children's services, as you know, we run various programs for the Ministry of Community and Social Services. Our staffs have

met on a number of occasions, most recently last Thursday or Friday, and those services will be maintained. The question is, are they going to be maintained there or where? But, again, no service is going to be arbitrarily severed and cut adrift. They will carry on.

**Mr. Duksza:** It boggles your mind when you opened Pandora's box. You've been meeting those doctors from breakfast to midnight supper.

**Hon. Mr. Timbrell:** That's fine.

**Mr. Jappy:** Mr. Chairman, the Charlton adolescent unit has been slated—there have been ongoing negotiations with a private board for a considerable amount of time now. I believe the chairman was here in front of this committee about a week ago. I believe it is ComSoc's intention to divest it to this board and then this board makes a decision where they wish to relocate. There seems to be some concern that there may not be sufficient funding, but we have agreed with ComSoc that should that need arise, then we have to take that responsibility on between ourselves.

**Mrs. Campbell:** You should be afraid of that one.

**Hon. Mr. Timbrell:** Mr. Chairman, there was one other thing that I want to respond to before my very brief summation. The member for Etobicoke (Mr. Philip)—I guess this must have been in the throne speech debate or the budget; no, it was in the budget debate—last week expressed some concerns about the outpatient programs, and said, "I am assuming the minister will read this speech." I want him to know I have read it and responded to the concerns he outlined, which obviously reflected the mistaken impression that the outpatient programs were going to be closed. They are not. Also, the \$1.3 million is for additional programs over and above existing outpatient programs.

**Mr. Chairman,** rather than belabouring all the points again today, perhaps I can come back again tomorrow and respond to questions.

**Mr. Chairman:** As the minister has indicated, he is available tomorrow afternoon, so if the committee wishes, we will continue the exchange tomorrow after routine proceedings.

The committee adjourned at 5:51 p.m.

## SPEAKERS IN THIS ISSUE

---

Campbell, M. (St. George L)

Conway, S. (Renfrew North L)

Dukszta, J. (Parkdale NDP)

Gaunt, M.; Chairman (Huron-Bruce L)

Johnston, R. F. (Scarborough West NDP)

Jones, T. (Mississauga North PC)

Kennedy, R. D. (Mississauga South PC)

Lawlor, P. D. (Lakeshore NDP)

McClellan, R. (Bellwoods NDP)

O'Neil, H. (Quinte L)

Sweeney, J. (Kitchener-Wilmot L)

Timbrell, Hon. D. R.; Minister of Health (Don Mills PC)

**From the Ministry of Health:**

Jappy, W. C., Director, Psychiatric Hospitals Branch

**From Queen Street Mental Health Centre:**

Durost, Dr. H. D., Medical Director

Fisher, M., Administrator

Guirguis, Dr. L. F., Chairman, Medical Advisory Committee





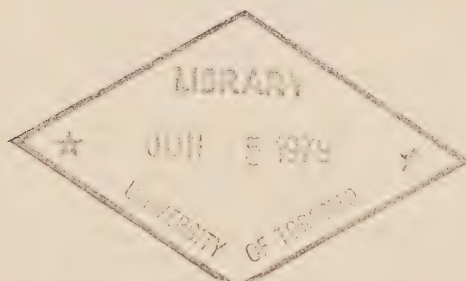
No. S-15

# Legislature of Ontario Debates

## Official Report (Hansard)

**Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Tuesday, May 15, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

TUESDAY, MAY 15, 1979

The committee met at 4:05 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Vice-Chairman:** The committee will come to order.

**Hon. Mr. Timbrell:** I am searching for some papers I wanted to hand out today.

**Mr. Vice-Chairman:** Excuse me, Mr. Minister. I just want to notify the committee that the minister has an appointment and he will be with us until 5:40 p.m.; so I'd like you to govern yourselves accordingly.

**Hon. Mr. Timbrell:** Thank you, Mr. Chairman. Could I just briefly sum up from yesterday? I also want to give some information to the members.

In all of these discussions—I have prepared a short statement for today—I don't want us to lose sight of the goal which we all share, namely, to ensure that the residents of Ontario have the best psychiatric care which we can provide. As a consequence of all the changes in psychiatric treatment—and these have been described in great detail to the committee—we have concluded that inpatients at Lakeshore can best be accommodated at Queen Street and Hamilton, while community-based outpatient services should be retained in the Lakeshore-Etobicoke area.

Most of the members, if not all, have seen the buildings and the facilities at both Queen Street and Lakeshore, and I don't think there is much dispute about which are the best. I might also add that we believe the reconstruction of Whitby, together with the space at Hamilton and Queen Street, will meet patient needs for provincial psychiatric accommodation in the foreseeable future. As a result, I believe that the main concern of the committee is with the outpatient services now provided from Lakeshore. As you have been told, we have begun a consultation process with various groups in the community to find the most appropriate services for this area. This, of necessity, is taking time. In the meantime, I want to assure the committee that all of the present outpatient programs at Lakeshore will continue uninterrupted until we have more appropriate alternatives.

Since we announced our plans, we have engaged in extensive community consultations regarding existing outpatient services and proposals to expand or to develop new services in the catchment area at Lakeshore. An outpatient implementation committee was established, which was broadly representative of those in the community with direct concern for mental health services. On this committee were the executive director of the Peel District Health Council, the executive director of the Hospital Council of Metropolitan Toronto, the assistant executive director of Mississauga Hospital, the executive director of Mental Health Metro, the medical officer of health and the nursing supervisor of the borough of Etobicoke, representatives of an organization known as Families and Friends of Psychiatric Patients, the president of the Volunteer Association of Lakeshore, representatives of Lakeshore Psychiatric Hospital and of Queen Street Mental Health Centre, the Ministry of Health program advisory branch and program development branch, the area planning co-ordinator for central-east Ontario and the director of the psychiatric hospitals branch.

The first meeting was held in the first week in February.

**Mr. McClellan:** How long do you intend to go on?

**Hon. Mr. Timbrell:** Just very briefly.

**Mr. McClellan:** A minute?

**Hon. Mr. Timbrell:** Two minutes. Give me two minutes.

**Mr. Duzsza:** He has already spoken for an hour and one half yesterday.

**Mr. McClellan:** He had two hours yesterday.

**Hon. Mr. Timbrell:** Mr. Chairman, the committee has been going for three weeks. There is so much to cover.

**Mr. McClellan:** He hasn't said anything yet.

**Hon. Mr. Timbrell:** At this meeting, the task of the committee was outlined and a decision was made to convene five separate subcommittees from each of five areas served by Lakeshore, namely, the city of North York, the borough of Etobicoke, the borough of York, the city of Toronto, and the region of Peel. The representative from the Peel Dis-



trict Health Council and the Hospital Council of Metropolitan Toronto agreed to convene the initial meeting of community representatives, similar to that of the parent committee, plus others as appropriate; social planning councils, inter-agency councils and so on. Each subgroup was asked to consider existing Lakeshore programs, plus new program proposals, and to make recommendations regarding each.

The recommendations of these groups were fed to the main committee, and their recommendations are those that have been or will be distributed. I'll pass those out at the closing of my remarks.

The main committee was augmented by representatives from each of the subcommittees. The recommendations about existing services were presented to the director of the psychiatric hospitals branch. The proposals regarding new and expanded programs are undergoing technical and financial review. When this is complete, decisions will be made about programs to be funded, taking into account priorities indicated by the committee group and the comments of the Peel District Health Council and the Hospital Council of Metropolitan Toronto, which have also been asked to review the recommendations for new programs.

Implementation of approved programs will be carried out with continuing consultation with these community groups and the staffs of Lakeshore and Queen Street and the ministry.

I realize this will take time, because there are hundreds of persons involved, but I believe the result will be a series of programs in the Lakeshore area which combine the best local judgement of the community's needs with the ministry's resources. That is our goal.

I'd like to give the clerk of the committee, first of all, a list of the program submissions we've had in relation to the money that has been protected from the savings associated with the inpatient programs, I think there are enough copies for the members of the committee. I am sorry, but there are only four copies of this, one of which I am going to keep. Can we get some more?

As well, I want to leave these recommendations regarding the existing outpatient services at Lakeshore. As I say, I am sorry that there are only three copies available for distribution. They are printed on both sides. Perhaps the clerk could get some copies made. I am sorry we don't have enough. We do have some more here; they were just all stapled together by mistake.

Mr. Chairman, that concludes my remarks. I just wanted to make those brief remarks because, on reflection, I thought it was an area that I hadn't covered yesterday.

**Mr. Vice-Chairman:** Mr. Lawlor?

**Mr. Lawlor:** Mr. Chairman and members of the committee, I had hoped the minister yesterday would have shown more grace and been more open-handed, considering the long time we have sat and the very numerous witnesses we have heard.

Yesterday, with respect, was a repetition of what we've heard from the very beginning and largely an exercise in equivocation. The minister said perhaps a little more today, which is helpful with respect to the outpatient situation.

We all know there was no prior consultation with respect to this closure; it was done unilaterally and contrary to the major report. I won't repeat all that; we know it only too well.

I put it to you, Mr. Minister, that the overwhelming evidence presented by witnesses who, initially at least, would have been considered favourable to you—witnesses whom your contingent insisted we call—was overwhelmingly, sometimes with caveat, the same proposition, namely, the closing was precipitate, unplanned and, certainly in the long term, terribly questionable. The gravest doubts have been sown, I put it to you, in the committee in this particular regard.

[4:15]

What we're asking you to do is to reconsider your position with respect to the planning aspect. You yourself, whether you're quoted properly or not in the newspaper article the other morning—I've never known Rosemary Speirs to be wrong—

**Hon. Mr. Timbrell:** She didn't call me.

**Mr. Lawlor:** "Not many people anywhere have a lot of experience in closing hospitals and moving staff and patients," he said—the "he" being Mr. Timbrell, "I'm always open to reasonable arguments about timing." You haven't particularly indicated that. You have a gift with respect for obfuscation in these particular regards. Sometimes—and I won't make a very personal attack; I'll just skip over it—

**Mr. Conway:** That's not necessarily not making it.

**Mr. Lawlor:** Well, I'll make it succinctly. You're the emperor of soft soap. I wonder sometimes whether it's Lifebuoy, Palmolive, carbolic soap—mostly it's that—or Irish Spring.

**Hon. Mr. Timbrell:** I have a choice?

**Mr. Lawlor:** Whatever the odour is, boy, you have lots of lather. You skate around an issue, and I expect you might do some skating this afternoon. Our job is to stop you from doing that and to try to bring some definition into this issue.

Again, in the vaguest possible terms, you say you're going to retain the outpatient services and in place, which is at least what I want. What are your plans—and give me something concrete—in respect to that alcoholics unit? Is it going to be permanent? Is it even going to be quasi-permanent? Is the unit to be retained where it is at the present time or not? I have questioned. In the course of my statement I shall question.

**Hon. Mr. Timbrell:** Mr. Chairman, I think that the member—perhaps he has it before him now—will see that the implementation committee for outpatient services, in assessing the alcoholism treatment services, indicated that the present program might reasonably remain where it is until an appropriate location can be found elsewhere.

**Mr. Lawlor:** What in God's name does that mean?

**Hon. Mr. Timbrell:** With respect, I think, you'd have to ask the implementation committee, which made the recommendation. Essentially, what they've said was that they feel the service should remain in Etobicoke. They allowed as how it might go to Peel if transportation were provided for the residents of Etobicoke, or in reverse order.

Perhaps Mr. Jappy can bring you up to date on the discussions he's had—I think there was some reference to this yesterday—with the present director of the program.

**Mr. Jappy:** Further to this recommendation from the implementation committee, we also had an advisory committee review the alcohol services program at Lakeshore Psychiatric Hospital. As I indicated to you, it consists of two portions: the elective program, which consists of a one-week inpatient and three-week day-care program, and another portion, which is a detoxification program.

It's their opinion, which is consistent with that in other areas of the province, that the detoxification program could be removed and run as we run three other detoxification programs in Toronto; in other words, offsite and not necessarily contiguous to a psychiatric or general hospital, and that backup services be provided by an emergency department in a general hospital with, naturally, a communication link so that once the patient is detoxified he has the choice of enrolling in the elective program.

As we indicated yesterday, out of 234 patients detoxified in the last four months, I believe, only nine have chosen to accept the elective four-week program which Dr. Maharaj now is running. Which again lends weight to the fact that the detoxification unit doesn't necessarily have to be contiguous to the elective program.

**Mr. Lawlor:** Let me ask the question the other way. Maharaj's opinion with respect to the detox centre is well known to be "Band-Aids." Nevertheless, why take it away from there? Why are you so anxious to remove it?

**Mr. Jappy:** Because in a detoxification program, particularly in a psychiatric hospital, you get the double stigma, whether you accept that or not. You not only have the stigma of the alcohol program, but you also have the stigma of the psychiatric hospital, which is still very real in this day and age.

**Mr. Lawlor:** But you're destroying the psychiatric hospital on one hand, and I'm asking about the alcoholic program on the other hand.

**Hon. Mr. Timbrell:** Can I just back up to a significant point that bears repeating and perhaps hasn't been made well enough for the honourable member to recognize it? That is, none of the programs is going to be arbitrarily cut off at any particular point in time. Some people are under the mistaken impression that as of September 1, no matter what, every outpatient program will either be moved or cease to operate. That is not true.

What I indicated on April 23, and again yesterday and today, is that we've had recommendations which suggest various other programs in whole or in part might continue on the Lakeshore site. We're prepared to consider those, weighing them against the alternatives; so there will be no interruption in any of these programs. Any that would move, in whole or in part, would be moved in such a way that there would be no hiatus period of weeks or months between.

**Mr. R. F. Johnston:** I'd like to correct the assertion about the nine people. We've talked with Dr. Maharaj's unit since that assertion was made yesterday, and we're informed that until April 7, 24 out of 260 went into the elective program afterwards, and that nine out of 52 have gone in since April 7, according to them.

**Hon. Mr. Timbrell:** You might ask Mr. Jappy where he got his numbers.



**Mr. Jappy:** The figures I quoted to you, I got directly from Dr. Maharaj last Friday morning.

**Mr. R. F. Johnston:** I think the figure you've used recently—nine—is right as of April. But I think you've got it incorrectly, from what I gather, having talked to Dr. Maharaj again. He is absolutely adamant. He believes that it's a crucial part of the program. He doesn't see his detoxification unit as merely that; he sees it as part of a psychiatric process. Whether or not they then go into the elective program, he sees himself as doing more than just detoxifying people. And, with respect, I think that emphasis of his is not being respected.

**Hon. Mr. Timbrell:** That's your feeling. That's fine.

**Mr. McClellan:** That's also Dr. Maharaj's feeling.

**Mr. Lawlor:** I don't think it's wise to misrepresent the position of Dr. Maharaj.

**Hon. Mr. Timbrell:** There have been many positions advanced.

**Mr. Lawlor:** Could you go along this far with me about these programs? I'm going to mention six of them, and I want to tie them down as much as I can against the slipperiness. The occupational industrial therapy unit, including the outgate program for seniors; is that going to remain? And could you possibly use the word "indefinitely"?

**Hon. Mr. Timbrell:** First of all, I want to take exception to this nonsense—a stronger word comes to mind—about "slipperiness." You criticized us earlier, saying that we don't involve people. In point of fact, in a decision as major as the decision to close out an inpatient program, that kind of thing you have to make in the ministry at the cabinet level and make your plans to follow up on it.

Having made that decision, we have involved many community and professional organizations, as I have already outlined. We are now considering the recommendations which are before us, which have come from those people. Having finished the technical and the financial reviews of those programs, we will then go back to those people, before they are finally implemented, so that they will be completely involved again. That's the kind of participation which I think you would agree is appropriate in developing these kinds of programs and making these kinds of decisions.

**Mr. Lawlor:** I would have you study what Dr. Wasylenko had to say with respect to the chaotic and incoherent schemes that you've thus set up on an ad hoc basis.

**Hon. Mr. Timbrell:** I would have to say that we are trying to be extremely careful in not rushing any of these decisions so that we do in fact involve appropriate people. I would invite you to look at some of the other testimony.

**Mr. Duksza:** Whose?

**Hon. Mr. Timbrell:** The testimony has not been all one-sided.

**Mr. Duksza:** Who are you quoting?

**Hon. Mr. Timbrell:** I wasn't quoting anybody.

**Mr. Duksza:** Then quote. He is saying very specifically Dr. Wasylenko. If you have any contrary evidence, then quote it. Whom are you saying supports your point of view?

**Hon. Mr. Timbrell:** I think that we might look at the evidence from the director of Mental Health Ontario, who met with you last week and who, I understand, had a difficult time making himself heard over the badgering of at least one group of members.

**Mr. McClellan:** That's simply untrue.

**Mr. Duksza:** I questioned him quite extensively.

**Hon. Mr. Timbrell:** So I heard.

**Mr. Lawlor:** I'm asking also, at the very least, that you do give consideration to a crisis intervention centre being retained on the grounds at Lakeshore with respect to this.

**Hon. Mr. Timbrell:** There are two crisis intervention centres proposed, one at Etobicoke General Hospital and one at Mississauga Hospital.

**Mr. Lawlor:** I'm aware of the proposals, and I'm aware of what you're doing at the crisis intervention centre at Queen Street, which I think is very questionable indeed.

**Hon. Mr. Timbrell:** Dr. Durost is here if you would like to ask questions about that; perhaps he will be more specific. These are very fine people who run these centres, and to make that kind of a comment without being more specific, I think, is to cast a slur against them.

**Mr. Lawlor:** Against whom?

**Hon. Mr. Timbrell:** The people at Queen Street. You say it's questionable.

**Mr. Lawlor:** I'm only quoting from the union brief in this particular regard and from statements they have made.

**Hon. Mr. Timbrell:** You said you thought it was questionable. If you want to question Dr. Durost, he's right here.

**Mr. Lawlor:** I wouldn't want to offend him at this particular second.

**Mr. McClellan:** We have done that already.



**Mr. Lawlor:** I'm only asking for a boon and, if I ask in too assertive a fashion, I'm not likely to get it. I'm not likely to get it anyway, but I want a crisis intervention centre considered.

What is your position with the SOC unit for the mentally retarded with emotional problems? What do you intend to do there?

**Hon. Mr. Timbrell:** Again, we are working with the Ministry of Community and Social Services on both the programs that we run for them. Again, nothing will be moved until a resolution is arrived at, by the minister.

**Mr. Lawlor:** Can I press you just a bit further? What does that mean, until a resolution has been arrived at? Until you find alternative accommodation; is that what you mean?

**Hon. Mr. Timbrell:** Until ComSoc has found what it considers to be a satisfactory alternative for either or both of those programs. Again, they are not going to be summarily chopped off at a given date.

**Mr. Lawlor:** And, again, in the Lakeshore?

**Hon. Mr. Timbrell:** I would anticipate that. You would have to ask the Minister of Community and Social Services (Mr. Norton) because, as I recall—and I'm subject to correction—the residents of those two units are drawn from a much broader area than just the former Lakeshore catchment area. They're drawn from a very wide range.

**Mr. Lawlor:** The aftercare clinics at present supplied by outpatients and community clinics; what are your intentions there?

**Hon. Mr. Timbrell:** Essentially, it is to stay where it is. There is some comment, I guess coming from the Peel group, that some of the aspects of the service provided there eventually will be developed in Peel.

**Mr. Jappy:** The Etobicoke group suggested that the program, or part of it, might be moved into the north half of Etobicoke to provide services up there, since everyone has to go down to the south end right now. That was the suggestion that was brought forward by the Etobicoke group. But it certainly hasn't been refined to the point where any definitive plan has been put forward. Therefore, that program would stay there at this point in time.

**Mr. Lawlor:** It would be costly and difficult to find a location in the other communities thereabouts, I think you would have to concede. I question very much whether that will ever get into place.

**Hon. Mr. Timbrell:** If you're right, then it will stay where it is. But, essentially, what Mr. Jappy is telling you is that the recom-

mendations that have come from the community groups are that they would like to see this service delivered in a manner that they think is more appropriate, namely, to spread it out from its present site to where the population is.

[4:30]

**Mr. Lawlor:** Let me ask you the final thing here with respect to child and adolescent care. You may reply that it is Mr. Norton's baby but, again, you have some responsibility.

**Hon. Mr. Timbrell:** Oh, indeed. We have a service that we run for them and charge back. Again, discussions have been held; as recently as Friday, there was a meeting with officials of ComSoc. It will stay where it is until such time as ComSoc has found a suitable alternative.

**Mr. Lawlor:** And speech therapy?

**Hon. Mr. Timbrell:** Essentially the same.

**Mr. Lawlor:** Are you going to leave it, or are you shifting it over to LAMP, the Lakeshore Area Multi-services Project?

**Hon. Mr. Timbrell:** There was some suggestion that that might be relocated at LAMP so that a broader community than just the psychiatric population, inpatient and outpatient, might take advantage of it; that will be considered in the proposals I described. I would reiterate that the technical review of the new program submissions and the financial review will be completed and then recommendations will be made in the ministry as to how to respond. Then we will go back to the implementation group to review these with them before implementation begins.

**Mr. Lawlor:** And the behaviour therapy unit? You talk about putting it in a hospital, but there's no definition.

**Mr. Jappy:** As a matter of fact, I had a discussion with Dr. Neiger, I believe it was about a week ago. There was some concern raised at this committee that his program was in jeopardy because (a) a secretary who was extremely valuable to the program had been given a layoff notice which was consistent with the collective agreement and (b) there were three part-time workers who had also been given layoff notices because again, consistent with the collective agreement, all part-time people must be given layoff notices before any full-time people.

I talked about this very problem with the committee consisting of ministry and OPSEU officials, I believe a week ago, and very fortunately the secretary in the unit was the next on the seniority list; so we assured her that her job was secure and, instead of looking for other positions, she could stay there.

The other problem, with the part-time people, I have been discussing with the OPSEU people, and I believe we have another meeting on Thursday. These people do go through a fairly extensive training program. It's not the type of thing where you can take someone else and have them perform this function immediately. They would not be jeopardizing, since they are part-time positions, those on the layoff list. This has not been finally resolved but it is certainly approaching that point, and I hope we will have a resolution on it perhaps on Thursday, I think it is, when we meet.

**Mr. Lawlor:** But what I am saying to you is, since you are leaving a fairly considerable list of facilities and services on the grounds, —at least indefinitely—why not leave the others such as the behaviour therapy unit? The building is going to be utilized anyhow; so why disrupt that particular operation,

**Hon. Mr. Timbrell:** If I may try to answer the member's question, there are a couple of areas in here where the committee—again, these are mainly people outside of the ministry—have identified services that perhaps could be afforded to a broader population if they were provided offsite. One is the suggestion of speech therapy going to LAMP. Another would be behaviour therapy, where the suggestion is that there be some discussions with one of the hospitals in Etobicoke such as Queensway or Etobicoke General but certainly to ensure that there's continued provision of the services to those who are receiving them now and as well the possibility of expanding their availability even further.

**Mr. Lawlor:** I won't take much more time. Perhaps one of the other members of the committee would want to come in on those particular matters. The last one is the dialysis. I take it you are determined, on that particular one, that Whitby is going to be the site and there's no question about it. No?

**Hon. Mr. Timbrell:** No.

**Mr. Lawlor:** This could very well stay?

**Mr. Jappy:** Yes, that's an excellent assumption, Mr. Lawlor.

**Mr. Lawlor:** I'm glad to hear that. That's an excellent reply too. I don't want to take too much time; so let me keep going.

The next thing that bothers me is you know what I have suggested, with respect. The union brief contains good points about a phasing operation. It bothers me enormously—and still does—if you had \$26 million or so available for this, that your ministry, as I suspect, had never discussed the busi-

ness of phasing both operations and retaining both Whitby and Lakeshore, working in now buildings over periods of time, so that it did not act as a burden either upon you or the Treasurer with respect to capital expenditures.

As I say, I suspect that you never have given consideration to splitting the funds with respect to the possibility of putting up buildings or renovating on either site over a period of a decade; to spreading it out and being able to retain this particular thing at Lakeshore—in a reduced way, admittedly, but being retained. Did you consider that aspect and that possibility?

**Hon. Mr. Timbrell:** No. If it hadn't been for the fact that there was this capacity at Queen Street and Hamilton, that may well have been something that would've been considered. However, the fact of the matter is that there is the capacity in the most modern psychiatric facilities in the province.

I think I told you once before, either publicly or in a private meeting, that the first visit of any kind that I made after becoming Minister of Health was on a Sunday morning, to Whitby. The only person who knew I was coming was the then administrator, who is now at Brockville.

If you look at Whitby, and you look at Lakeshore, it seems to me that if you were to fly in the face of the availability of these facilities at Queen Street and Hamilton, it would have been a very serious mistake, because Whitby has to be replaced. Last year I was able to get all of the outbuildings torn down—all the barns and cottages and the like which sat there for years, boarded up, but which were a threat to everyone's safety and which had been the scenes of some problems over the years. But the facility has to be replaced in the quickest order. So, no, I didn't consider that, primarily because there was the space available elsewhere for Lakeshore.

**Mr. Lawlor:** I put it to you, Mr. Minister, that the Queen Street accommodation and capacity, even now, and certainly in the long term, as we have heard evidence before this committee, is a moot matter. It is a matter that, from your point of view and on your actions, is lending itself to great risks.

There are grave discrepancies between the union estimate and what has been presented by the mandarins of the establishment in this area—I call them Cecil Rhodes under my breath—in terms of the position taken by them over against the briefs that we saw, and which you managed to get watered



down a little bit, as to the internal functions of the hospitals.

It must cause you enormous concern that you may be choosing the wrong option here over against the McKinsey projections and over against what we have heard as to the possibilities of accommodation at that hospital, at least in seven years' time. It's so grave a matter with respect to the fact that once you've closed Lakeshore and torn down the buildings there'll be no reversal. I mean, the cat is out of the bag. Have you really profoundly considered that?

**Hon. Mr. Timbrell:** I don't think you can possibly occupy a position in the executive branch of government and not take into account those kinds of considerations when you are dealing with people's wellbeing.

**Mr. Lawlor:** You admit you can be wrong?

**Hon. Mr. Timbrell:** Indeed. I have never even had a smattering of socialist infallibility.

**Mr. Conway:** Unlike the Minister of Education.

**Mr. Lawlor:** She's highly educated.

**Mr. Conway:** If I may quote myself from this afternoon, she makes papal infallibility look weak-kneed.

**Hon. Mr. Timbrell:** I had missed the last part. I'm glad you repeated that—and she will be glad to know too.

We went at this many times. Repeatedly, before the decision was finally made and since, I have put it to staff: "Can we for certain accommodate these people?" It is not only a matter of just having a spot for them, but can they be treated as well or better?

We heard from Mrs. Lawlor her opinion of what is being done with her patients in the psychogeriatric unit since they were moved. The planning doesn't begin and end at the first quarter or the first half of 1969. Psychiatric needs will be continually evaluated every five or 10 years. I would anticipate the development of further community mental health programs, particularly the development of services like crisis intervention units in other parts of the community and the expansion of community psychiatric units, such as the expansion which will be under way at the Mississauga Hospital.

Your colleague from Etobicoke perhaps will have told you that some discussions have been begun recently with the administration of the Etobicoke General about the possibility in the not too distant future of expanding its psychiatric unit. All of this will have a positive effect on the rate of admissions to provincial psychiatric facilities. For the foreseeable future, with Queen Street and with

Hamilton—there has been very little discussion about the role of Hamilton, where there is a significant surplus of beds right now—

**Mr. Conway:** Such as it was; it was a little bit confusing.

**Hon. Mr. Timbrell:** At Hamilton?

**Mr. Conway:** Yes. But I won't belabour that point now.

**Hon. Mr. Timbrell:** Please belabour it at some point. I would be interested if there is a problem that has not been resolved.

**Mr. Conway:** Other members of the committee can correct me, but I do recall the administrator—perhaps the member can tell the story.

**Mr. McClellan:** I asked Mr. Morin, whether, on the basis of his operational plan, he wouldn't have to cancel plans for a forensic program, and he would have to cancel plans to relocate programs into the C2 ward from buildings which should be demolished. That was from his own operational plans. There is substantial dislocation of Hamilton as a whole.

**Hon. Mr. Timbrell:** I would like Mr. Jappy, as the director of the psychiatric hospitals branch, to speak to that.

**Mr. Jappy:** I would like to explain something. The operational plan is a new process that has been inceptioned in the ministry in the last couple of years, whereby each branch and each facility, particularly in the psychiatric hospitals branch, is asked to put down in writing what it would like to do and what new programs it would like to bring into being, provided the dollars are available.

**Mr. Duksza:** Mr. Jappy, he is not talking about new programs. He is talking about cancelling all the programs to accommodate the patients transferred from Lakeshore, which is quite a different matter.

**Mr. Jappy:** Pardon me; cancelling what?

**Mr. Duksza:** He says cancelling two programs to be able to accommodate extra patients in Hamilton. You have both suggested that it was possible for Hamilton to take a significant percentage or otherwise of the Lakeshore catchment area and the patients. He is saying that he would have a significantly modified operation. He was not talking about future projections.

**Dr. Surplis:** That was a hypothetical number. It was the 100 a year or something additional patients. How many were you talking about?

**Hon. Mr. Timbrell:** How many have actually been transferred? Four people?

**Dr. Surplis:** Four or five.



Mr. Dukszta: Hamilton is not to be taken into account at the moment. It is really taking very few, and you cannot really count on it solving the problem as a catchment area of the Lakeshore.

Mr. Jappy: Hamilton doesn't have a forensic program at this point in time. Hamilton has a basic assessment program; it does not have a full-blown forensic program. What they have suggested in their operational plan is a considerable forensic program amounting to—I forget the figure, but it is probably \$600,000 or \$700,000 of staffing and a 32-bed unit, which they certainly don't have at this point in time.

[4:45]

Mr. Dukszta: Mr. Jappy, we are not talking about the future here; we are talking of the beginning of the program that we have now.

Hon. Mr. Timbrell: I thought you were suggesting that a forensic program would have to be cancelled, and Mr. Jappy is saying there is no forensic program to cancel.

Mr. Dukszta: It is quite true; there is a problem which deals with this, sir.

Hon. Mr. Timbrell: I think Mr. Jappy has submitted, for the record, what is there.

Mr. Dukszta: I am quoting from Mr. Morin directly.

Mr. McClellan: He is stating what Mr. Morin stated.

Hon. Mr. Timbrell: But I thought you were suggesting that the program had to be cancelled. Mr. Jappy has put it into the proper context, that it is something that has been suggested—

Mr. Dukszta: We are not suggesting; Mr. Morin is suggesting.

Hon. Mr. Timbrell: —as a possible idea for the future, but there is not a forensic program there to cancel now.

Mr. Dukszta: But you are counting on all those medical beds, when we come to examine your medical beds—

Hon. Mr. Timbrell: Yes. In transferring the east half of Halton—

Mr. Dukszta: —and we are just pointing out that Hamilton cannot support some of your planning.

Hon. Mr. Timbrell: In transferring the east half of Halton region, that has meant a movement to Hamilton Psychiatric Hospital of, I think, four or five patients; and, of course, there is a community psychiatric program unit at Oakville Trafalgar Memorial Hospital, which is in the east end of Halton and serves that area pretty well.

Mr. Lawlor: Just on that point, if I may, I mean on page five of the operational plan 1978-79, it does mention the forensic program. There are 30 beds at Century Manor; and, blast it, acting in the Justice ministry, there is a crying need for a forensic program in the Hamilton area. If you are going to move patients in on that, then the plan will never go into effect and they won't have assessments, made from the courts, which you cancelled earlier on.

At page five, he tells what happens at C2 ward and what he wishes to do with it. He says in the last paragraph: "The 20 beds unallocated at C2 will eventually be used to develop a special program for evaluation of some categories of schizophrenic patients."

What you are really saying, as I read it, is that it won't happen, that's all, as far as you are concerned.

You seem to me to throw Hamilton in as a kind of way of diverting attention.

Hon. Mr. Timbrell: Not necessarily.

I am just trying to clarify it in my own mind, because there was a program that decentralized 14 or 15 months ago, long before any decision was taken on Lakeshore—a rearrangement of programs at Hamilton—

Mr. Dukszta: You seem to be shocked, Mr. Minister, by the whole system. He doesn't seem to have a basic—

Hon. Mr. Timbrell: Mr. Chairman, with respect, this is a massive system. I do keep myself pretty well abreast of what's going on. What I am saying is that there was a decentralization or rearrangement of some of the services, going back a year ago in February or March at Hamilton Psychiatric Hospital, long before any decision was made about the closure of Lakeshore. I am just wondering if that's what you are quoting from. I am not sure. I haven't got a copy of that in front of me.

Mr. McClellan: Forty-eight of the beds that are being made available in Hamilton will come out of the C2 ward, and it was the intention of Mr. Morin to relocate services that now are dispersed in buildings located on the grounds which should be demolished. Those services are homes for special care, chaplaincy psychology, and the vocational recreational officer. So you made 48 beds available in Hamilton by cancelling a program to relocate services out of buildings that should've been demolished.

Hon. Mr. Timbrell: All right, let's go back and look at services that are being used now. In the area which has been transferred to Hamilton as a part of the catchment area, the eastern half of Halton, I think you'd agree

it would be desirable, where possible, to keep whole municipalities assigned to a hospital. Four or five people were transferred. You may wonder, why so few people? I think a good reason for that is the community psychiatric unit that exists at Oakville Trafalgar hospital now and serves most of the institutional needs of people in that area.

**Mr. R. F. Johnston:** Can you show statistically that that's what does it?

**Hon. Mr. Timbrell:** I think that's a good factor. I thought your party, as I read resolutions from your last convention in Ottawa, believed in moving away from large institutions, and here you keep arguing—

**Mr. R. F. Johnston:** I am not disagreeing, I do. You are saying categorically that's what has done it, and I am just saying show us the statistics which show that.

**Hon. Mr. Timbrell:** I am just saying, Mr. Chairman, I am sorry, I am not the director of mental health of Ontario and I am not about to be badgered like that.

**Mr. Duksza:** But you are the minister.

**Hon. Mr. Timbrell:** The fact of the matter is that program has a very good reputation. I think that's a significant factor.

**Mr. Vice-Chairman:** I have a list, gentlemen. There has been a digression here but I think we'll follow the list. Mr. Lawlor.

**Mr. Lawlor:** There are about two other matters I want to discuss and I'll do them very quickly. One of them is the fire hazard. I am not going to spend five minutes on it. I am going to say though, Mr. Minister, I really am irked with you about that fire situation. When you had your press conference, which I attended, on the announcement of this closing, you, three different times, in the course of discussing this with the press, and which by the way had the effect of turning the press off on this whole issue, insisted upon the fire hazard at Lakeshore. We've had four witnesses, including the Ontario fire marshal, say it's a will-o'-the-wisp and it's a fabrication by you. I think you should have the courtesy to withdraw your remark.

**Hon. Mr. Timbrell:** No, Mr. Chairman, I was expressing a personal opinion.

**Mr. Lawlor:** Boy, did it ever have an impact!

**Hon. Mr. Timbrell:** As I pointed out to you yesterday, if you look at the early pages of the McKinsey report, the reference is to fire problems.

**Mr. Lawlor:** We have had far more extensive evidence now, from Mr. Bateman and others.

**Hon. Mr. Timbrell:** If you look at the report of our own Mr. Manson of early 1978, it again predates any decision. I was expressing a personal opinion which I still hold.

**Mr. Lawlor:** Queen Street has had four fires, two of them caused by arson. This one you are talking about that disturbed you so late at night was a fire caused by arson. That's all. Concede that.

**Hon. Mr. Timbrell:** Yes.

**Mr. Lawlor:** All right. I don't want to dwell on that.

We heard, from my point of view, an awful lot of pie in the sky with respect to community health services. They have been around a long time and there is not apparently a great deal done. We heard from Parkdale residents particularly.

The basis of arguing you are precipitate in your judgement on the Lakeshore thing really gravitates around that particular issue. The chronic home care is not in place and there are housing problems of a great magnitude. I heard you say yesterday and I agree with you, that the municipalities are not showing a sufficient social consciousness with respect to group homes, and something is going to have to be done about it.

For people to set up an ideal system and put that over against the pie in the sky, however one likes that type of pie—I hope it's lemon—doesn't help the situation as things stand at present. Questions of co-ordination were constantly repeated, even by the man you flew in from Ottawa. He vastly preferred a co-ordinated system but we kept on saying, "We all do." There may be a day when we can close down every psychiatric hospital in the province. That would be great if that were possible in terms of home delivery and home care, but the situation is just the contrary.

**Hon. Mr. Timbrell:** You know and I know that day will never come.

**Mr. Lawlor:** All right. As an ideal, some kind of thing to be striven for, it is fine.

**Hon. Mr. Timbrell:** With respect, I don't think anybody would even agree it's an ideal to be striven for, to close down every psychiatric hospital. Nobody in his right mind would even suggest that. Nobody even not in his right mind would suggest that.

**Mr. Lawlor:** That's because you think there are psychotic people around.

**Mr. Conway:** I am not about to be striven anywhere.

**Mr. Lawlor:** I'll take exception to it. Would that this society were such that people



were not rendered psychotic because of the conditions about them; that would be desirable. It's conceivable that such a society may come into being.

**Hon. Mr. Timbrell:** That's also not going to happen.

**Mr. Lawlor:** It would have to be socialist, I have to admit, but it might—

**Hon. Mr. Timbrell:** You see, you just made my point.

**Mr. Lawlor:** —be something to strive for. You would have to have a far greater sense of society at least than the present individualistic mess does, which drives people crazy.

In any event, this is the area. The emphasis being placed, particularly by ministry witnesses, on some nebulous never-land which exists, you see, as an alternative to psychiatric hospitals and this particular hospital, just doesn't impress me. I want you to know that. I don't think it should weigh heavily with you either as the Minister of Health with responsibility for that kind of thing.

Get your chronic care, get your housing, get your vocational services, get your senior citizens' home into play and then close these hospitals.

**Mr. Conway:** I won't belabour many of the points which the local member has put so well. I want to begin my comments with two or three points which, from my point of view and from the point of view of my party, deserve a review and a summary.

When on January 22 you announced here in Toronto that you were about to close Lakeshore Psychiatric Hospital, I wasn't able to attend that press conference, but I do well remember the public response, and particularly the media response to the impression you left. It was one which had been encouraged and cultivated in the House somewhat later, I suggest. That was, that among the principal reasons why the facility at Lakeshore should be phased out quickly was that it was a firetrap that you did not want on your conscience and, by implication, we other members should not have on our consciences.

When I heard that, not being conversant with the physical plant and being impressed by the case you did seem to make, I was prepared to accept what you had to say and I did suggest tentatively to the press on that occasion that your case, on the basis of the fire hazard particularly, was a good one and I could live with it. Like other members of this committee I have been interested to hear the evidence and the testimony in that connection over the past four weeks.

Like Mr. Lawlor, and I suspect like many other members of the committee, I sense a certain deception of one kind or another has been visited upon me. I really have got to say this. Notwithstanding the fact it is an 89-year-old building which I am sure does have its problems, to which McKinsey and others have made reference, I, like the member from Lakeshore, have been impressed by those witnesses who have come before us and indicated it is not a firetrap. Indeed I think one or two of those witnesses indicated that with normal maintenance it could serve institutionally for at least a few more years.

I dare say if we applied your standard to this old barn in which 125 of us work, we would probably all be out in the park or out at Lakeshore because I am sure it would not meet the standards which you have laid down for Lakeshore.

**Hon. Mr. Timbrell:** But you don't live here, Mr. Conway. That's the difference.

**Mr. Conway:** I don't know that you are in a position to make that judgement.

**Hon. Mr. Timbrell:** You have found facilities here that have eluded me in eight years, then.

**Mr. Conway:** They may not be quite up to the scratch of the Hepburn Block, I can assure you, and indeed the Speaker does live here.

My point is simple. The firetrap argument has been rendered nugatory and I want to say I am a little irritated. I think there was almost a calculated scare tactic to drive a lot of us into the camp of closing that facility because we could be facing a calamity. I resent that and that one argument as washed pretty poorly in here on the basis of the expert witnesses we have heard.

Secondly, I have sat here for four weeks. I have tried, like all members, to approach the matter with objectivity and balance.

**Mr. R. F. Johnston:** I didn't.

**Mr. Conway:** Well, the novice from Scarborough West will learn, and he is very impressive.

**Mr. R. F. Johnston:** Don't keep putting that on the record.

[5:00]

**Mr. Conway:** Martel will be on the back bench in another year. I want to say I have listened to a lot of very impressive people.

I looked at the witness list here just before beginning my comments and I was looking back again at the minister's opening statement. I don't really look at the April statement; I am much more interested in the



initial document issued by you on January 22.

It is very difficult to sit and engage in this kind of debate over four weeks on the assumption we are here to discuss a decision that has something to do with the input of good health care planning, because clearly it doesn't. You admitted it, for me at least, on the second page of that January 22 statement when you said: "Our review of the McKinsey document was well under way when it was overtaken by budgetary considerations." We are here to discuss a decision that has very little to do with good health care planning, in my view, and an awful lot more to do, to use your phrase, with budget considerations.

In that connection, it almost reminds me of the debate in this committee a year ago, which I am sure a lot of us don't want to be reminded of, about the OHIP premium. We had a parade of high-priced talent from the government come before us and tell us all that had to do with good health care planning, when we all really knew and when it was happily, but somewhat in an unplanned way, indicated to us that Darcy McKeough and budgetary considerations were the only factors in that particular health care initiative. I was unhappy to see the straw men and the cards built up to justify something which many people in the Ministry of Health knew to be quite unjustifiable.

You are quite right, Mr. Minister, in suggesting the evidence has not been unanimous. I would be the first to admit we had visitations from people like Dr. Roberts from the Royal Ottawa Hospital which were sharply contradictory in some respects to others of the professional psychiatric witnesses before the committee. We have had other such differences of opinion.

I don't think I am being unreasonable when I suggest that a certain impression has been created for a lot of members. I think it has been a productive exercise. I know the ministry feels very unhappy about the fact that in over four weeks we have tied up as many people as we have. I suspect there is a wistful longing in your ministry, perhaps more than others, that we could return to the old days of estimates where we could all gather for 20 hours and very happily meet to discuss the line-fence politics of our individual constituencies without ever really being able to marshal our resources to scrutinize what a growing bureaucratic government is doing in our so-called public interest.

I want to say to you that if I have anything to do with estimates, and at least two of the three House Leaders are here to hear

this, I would like to think that the sort of reference that has brought us here—and whether or not that is the kind of mechanism we want to continue with is not for me to say—for this kind of scrutiny of a major government initiative such as this one about institutional psychiatric services for a region as large as Metropolitan Toronto, is going to be the manner in which we deal from here on in with health care planning and health care policy because I have found it to be very useful.

I continue to get the sense of a minister with his eight fingers and two thumbs and, God forbid, perhaps even some of his toes in a dike which is breaking all around him. He is moving from one spot to the other to shore up an institutional and non-institutional delivery system which shows the effects of years of having money thrown at it—lots of money in the old days when John Roberts was Premier, I am told—and now as resources, financial and other, become more scarce, the house really begins to appear to crumble.

There has been no planning—it has been said by others and I have to repeat it. The impression I have been left with is of a harried minister and of an even more harried ministry scrambling about to deal with the budgetary restrictions that have quickly forced a re-examination of earlier plans, and then the rather lame and awkward justification of really the unjust.

This letter, for example—just to use one example—the statement of the minister was introduced on January 22, 1979, and, quite frankly, I suggest that it did not come as a great surprise to some people in terms of the actual attempted closure of the old facility.

But fully four months later we have appearing before us the chairman of the Queen Street Mental Health Centre—

**Hon. Mr. Timbrell:** Of the medical advisory committee.

**Mr. Conwag:** Dr. Guirguis, the chairman of the medical advisory committee at Queen Street—who comes to us, after having been reported in the local press pleading for some consideration in what's being done from the very people to whom the bulk of the Lakeshore catchment area is being directed. He is telling us, notwithstanding their earlier visit, about which I want to register some resentment—I don't know what in the scheme of things caused that meeting to occur over at the Hepburn Block on Monday morning. I didn't say it to the good doctor yesterday, but I'll say it in his absence today: I found a certain timidity in his performance yesterday that I did not glean from the letter written but three days be-

fore. And I will be as uncharitable as to suggest that some of that probably had a lot to do with the meeting that occurred at the Hepburn Block yesterday. Whether or not that is just is perhaps for others to comment upon.

It struck me as incredible that the medical advisory committee at the Queen Street Mental Health Centre had not been called to a more systematic planning mechanism. Just listen again to what they've had to say; these people, far more experienced than someone who lives 250 miles from the Queen Street Mental Health Centre, say: "In view of the rising service needs for an increasing population in the Lakeshore area predicted by the McKinsey report, it is impossible to state that the closure of Lakeshore is wise." They go on, in two and a half pages, to itemize an indictment of this plan which is, for me a least, of such a kind as really to require your ministry to make amends without which we will not allow you to escape this room.

I've never had the opportunity to have been in a government, but I cannot imagine a planning mechanism that would force a chairman of a medical advisory committee in one of the principal institutions to this kind of letter three or four months after the announcement was made. Really and truly, I despair completely of your capacity to plan anything if, in my view, such an elementary, preliminary, fundamental and basic step was not entered into from the very beginning. Quite frankly, I really and truly believe a censure of the most stinging kind is yours for allowing this kind of thing to happen.

They were the only ones. We had before us—and I think she is here today—a very charming and very delightful nonprofessional person, representative of the Lakeshore volunteers, to give us another completely different perspective; it was a plea—a cry almost—not to allow this to go on until such time as some kind of planning and some kind of co-ordination occurred. I want to tell you that that kind of evidence has meant a lot to me.

On the principal point—and I'll make my statement less lengthy than I originally planned—I want to highlight for you the pattern of what we have heard here for three and a half to four weeks. I suspect all reasonable members of this committee, quite apart from their original or continuing partisan predilection, will agree with me that your early point about the excess capacity at Queen Street is important; and that has not been lost on me. I really wondered though, after what I enjoyed as a good tour the other day at the

Queen Street Mental Health Centre, who was responsible for the planning which produced that empire, now discovered to be largely in excess of the requirements.

As a politician, and certainly as a taxpayer, I don't like the prospect of an empire down there on Queen Street operating at 60 or 70 or 80 per cent of capacity. I don't want to see that kind of situation continue. I want to censure you and the government—of which you are proud to admit you are an executive member—for the planning process that led to the creation of that facility, and I want there to be no misunderstanding of that whatsoever.

Once again, I despair at this government's capacity to plan for the future, given fewer dollars for institutional and non-institutional requirements, when, in the days when you had money, in the days you had some time, you created that kind of structure, now revealed to be well underused, and the committee is going to have to deal with that in one way or another.

From my position, I am shocked and alarmed at the totally unplanned, haphazard, unco-ordinated way in which this scheme was attempted. I am almost insulted to think that a battery of \$30,000- and \$40,000-a-year men of much experience would ever imagine that a committee in a minority Legislature would accept it. I am insulted to think that you and your ministry would believe we were so spineless and so beleaguered as to let you get away with it, because in some of its fundamentals you will not be allowed to. When you leave here today or tomorrow, this committee, in majority or unanimous measure, will have to weigh the evidence accordingly.

As far as allowing you to close Lakeshore as of September 1 is concerned, under the plan that you announced in January and under the conditions you established in April, notwithstanding your earlier comments to my colleague and my friend from Lakeshore—which seemed to be a white flag almost at every question—as a committee I hope we are going to insist that a much more systematic commitment be entered into. I hope that not only will we recommend certain things that will protect all of those outpatient services, that will provide the most efficient and the most qualitative inpatient facilities, but I expect, in fact, I will insist, an accountability of your stewardship in this matter before this committee in the not too distant future. Because, I would suggest, it is not going to be good enough for members of this committee to make a report, send it to the



Legislature and then carry on with other business.

I sincerely hope that this is the beginning of a new chapter, at least in a minority government environment. We are a legislative branch, not unmindful of the great and onerous responsibilities which you and members of the executive council share from time to time, but ours is a largely confrontational one where you are concerned; a lot of members in this Legislature have unfortunately not understood that. They imagine somehow that we, as committees, and we, as legislators, are here but to rubber stamp what you do in our name. I think that is quite a wrong impression.

I, and I hope other members, understand our responsibility to be one of accountability. I just want to tell you that I expect we will persuade you to revise your position substantially on both the inpatient and outpatient aspects, and that we will make a report to this House that I fully expect you and the government will accept in most, if not all, of its direction. Sometime in the not too distant future, before we are willing to allow you to go on to other business, we expect you to be back before us to give an accounting of your stewardship in that connection.

I don't ever again want to hear such stories about fire hazards where they do not exist. As the member for Lakeshore pointed out, and I use it as just another—

**Hon. Mr. Timbrell:** Mr. Chairman, on a point of order: Before the member gets himself totally worked up, would he not concede that in both the McKinsey report and in the report from Mr. Manson, who is an adviser in our institutional branch, that they did refer several times to potential fire hazards? [5:15]

**Mr. Conway:** If I am to respond to that, of course; of course they did. I would suggest to you as a principal planner and spender in the social service and social development sector, that if we were to take every social service institution in this province about which some comment has been made in connection to fire and fire-related hazards, I dare say in my riding, to name but one, there would be a calamitous situation and a great drain on your financial requirements, because I want to tell you what can be said of Lakeshore can be said of countless other hospitals, homes for the aged, nursing homes and allied social service institutions. So of course your straw man is a man to that degree, but the quality is not much more than straw in so far as this argument is concerned.

I just want to say that this kind of hapless, haphazard, unplanned attack on a fundamental service for an area as important to this government, my colleagues and all members of the Legislature as institutional health care services in Metropolitan Toronto, is going to be repudiated in substantial portion by this committee, I hope. I don't ever want to see the kind of specious, weak and almost insulting argumentation put before me ever again as one member of this committee.

I realize the poor Minister of Health, beleaguered as he is with a crisis in at least three other areas, to say nothing of federal-provincial relations, cannot fully acquaint himself with these matters. But I hope Mr. Jappy, I hope Dr. Lynes, I hope every bureaucrat in the Ministry of Health who has had anything to do with this committee in this inquiry, understands that there is a new resolve on the part of this committee and the members of the Legislature to scrutinize what I am unhappy to say in the past was let go, in most cases, unscrutinized.

Mr. Minister, I want to thank you for your appearance before this committee.

**Hon. Mr. Timbrell:** You're welcome.

**Mr. Conway:** I know that you will take the reports, such as they might be, with the seriousness that this committee directs them to you.

**Hon. Mr. Timbrell:** Mr. Chairman, I'll be fascinated to see that report, but I just want to make a couple of observations on the question of planning. I was very frank in my January 22 remarks about the process that had gone on, how we had come to that point on that Monday morning, but since then there has been a great deal of time and attention given to the implementation of that decision. As I say, I won't bore the committee yet again with the recitation of the process that we went through to arrive at that point of that decision; but since then there have been two groups working at the implementation of that decision. One is the inpatient transfer committee of which I think you're probably aware. That's made up of the administrators and the medical directors of both Queen Street and Lakeshore. I may say I'm no less disappointed to find that the internal communication lines of some of our facilities are not what I would have hoped they would be, and I'll just leave it at that. I think my concern about that is certainly well known in the ministry.

In addition, the director of nursing of Queen Street Mental Health Centre sits on the inpatient transfer committee, and the



director of the psychiatric hospitals branch, Mr. Jappy, or his representative, meet as well. And that group has met, what, weekly?

**Mr. Jappy:** It works out to be about every second week.

**Hon. Mr. Timbrell:** About every second week, ever since the decision was announced, to oversee the orderly transfer from Lakeshore to Queen Street of the inpatient population, so that there are no precipitate actions taken. In fact, there have been a number of occasions when plans have been made to move certain groups of patients that have been put off because either there were problems with staffing, people were on holidays, or not available, or there were problems in preparing the unit so that people would be moved appropriately.

There has also been the outpatient transfer committee. I just want to remind you again of the membership of that body because it's very, very large and diverse and their role is still continuing, as we view first in the ministry and then going back to them, the recommendations about the existing programs and the proposed new programs.

We've got the executive director of the Peel District Health Council, whose responsibility is to advise on all health matters in the region of Peel. There's the executive director of the Hospital Council of Metropolitan Toronto, who has been extremely helpful to us over the years in evaluating program submissions for mental health programs, be they in the community hospitals or in the communities. The assistant executive director of the Mississauga Hospital, a hospital that has a community psychiatric unit now which is being expanded, and again they certainly have a role to play here in planning.

The executive director of Mental Health Metro, the coalition, as it were, of most of the community mental health programs in Metropolitan Toronto, which are concerned about planning. I would remind you again that several of the submissions we've had, and I think they're very worthwhile submissions, have had to do with co-ordination at the community level with Etobicoke, within North York, within Peel, and the like.

**Mr. McClellan:** Several were critical of the process.

**Hon. Mr. Timbrell:** I'll come back to that. The medical officer of health and the nursing supervisor of the borough of Etobicoke—again, the health units certainly have a significant role which will continue in psychiatric matters at the local level. The representatives continue to sit on this group

from the organization known as Families and Friends of Psychiatric Patients, Mrs. Royce, the lady to whom you referred earlier, as president of the Lakeshore Volunteers Association sits on this group.

Again, representatives from both Queen Street Mental Health Centre and Lakeshore Psychiatric Hospital are on this group; so is the area planning co-ordinator for central east, whose responsibility it is to act as a facilitator and an expeditor for all aspects of health planning, working with health councils and organizations in individual hospitals. And the list goes on—there are representatives from the ministry itself.

**Mr. Chairman:** I make no apologies for the decision that was made, given the facts before me. I make no apologies for my opinion of that facility. I have the same opinion of Whitby. In fact, there I was able to do something about it last year in getting, destroyed I think it was 13 buildings, that I considered to be a potential hazard, and it will be totally replaced.

**Mr. Conway:** Just on that point could I interject? I don't wish to be personal, you know, but I'm really sometimes puzzled at the interface or the lack of it between your principal opinion and public policies as the Minister of Health. Here you talk about your personal opinion with respect to Lakeshore and the fire hazard which makes me think about credit cards, how it was your personal opinion to which on one occasion you had a desperate commitment, but days later personal opinion counted for much less in the public policy formation.

I wonder, and I don't wish to be too direct in that connection, but I don't know what of your personal opinion to take sometimes.

**Hon. Mr. Timbrell:** With respect, the reasons for making the decision were outlined in my statement of January 22. My personal opinions beyond that were inquired of and given after having stated the reasons that went behind them.

That was my personal opinion. We've debated the other matter and—

**Mr. Conway:** But you understand, as Mr. Lawlor pointed out, that I just used that example of the fire situation, because for those of us who weren't involved—in my case I was digging out of a snowstorm many miles from here—a variety of press people were phoning about this terrible firetrap that was at Lakeshore. That was the construction placed on it, and it puts many people, certainly the politicians, who are, in a parliamentary sense, put in an adversarial role in that connection, in a very difficult position, when the facts—and the facts in

that one November 1978 fatality were not, with all due respect, put forward with the kind of candour, frankness, and deliberation that I think the pyromania and the arson involved demanded. I want to make that point just once again.

**Hon. Mr. Timbrell:** To go back to the reasons for the decision, given the availability of modern facilities; given the lack of capital to replace Lakeshore in the future; given the condition of Lakeshore at this time; I still think it is the proper decision. With respect, I am certainly prepared to acknowledge that the followup by my ministry hasn't been all I would have hoped for.

Fortunately, in the process we have allowed for sufficient time—and in deciding to retain all of the land in public ownership, even more time prevails now—that we can be sure that, first of all, that inpatient transfers are not precipitate, and, secondly, that in planning for the continuation of existing outpatient programs and the development of new ones, all the necessary time will be taken.

**Mr. Conway:** Be assured, you sell Lakeshore and you sell your future hopes.

**Hon. Mr. Timbrell:** Mr. Chairman, the honourable member is engaging in some fiction, because there is no intention whatsoever of selling Lakeshore.

**Mr. Conway:** Well, that's important, and I accept entirely what you have said and have said before. I was quite concerned, when I went out to the campus and talked to some of the area people at the Port Credit meeting, that that was perhaps your intention in the beginning. There is great concern in the community that some effort is being made to sell off. God knows the government has been selling off a lot of its other assets. There was a great concern among the public that that was going to happen to land that had been in the public domain for a long time.

I think your commitment in that connection is an important one, and I thank you for it. As all members, and particularly the member for Lakeshore, pointed out, there was great concern that this large, beautiful campus in that area of west Toronto was going to be sold from under the very community that had grown up around it.

I just want to highlight again the importance, I believe, of your commitment; one that we will make very sure of; to keep that particular campus, that property, in the public domain.

**Mr. Duksza:** Mr. Minister, your decision to close Lakeshore has to be examined from a number of points. Some of them were listed

in your statement of January 22 advising why you are closing Lakeshore.

The one thing that is very clear is that it was less related to imperatives of the provision of psychiatric services in the area than to budgetary restraints. Yet in your statement you quote the three themes which you use to substantiate your closing of Lakeshore. One is the general one, which by now is clear to all, that Lakeshore is an old firetrap.

**Hon. Mr. Timbrell:** With respect, Mr. Chairman, I did not use the term firetrap in my statement.

**Mr. Lawlor:** You used it at the press conference. You won't find it in the statement.

**Hon. Mr. Timbrell:** I said it was unsafe.

**Mr. Lawlor:** You made a speech afterwards in which you did say it.

**Mr. Duksza:** Mr. Minister, one way or another you have suggested that one of your reasons for closing Lakeshore is that it is an old, unsafe building. The impression you left, whether by your speech, by reports or otherwise, was that it was in fact a fire hazard. I don't want to deal with that further, because both Mr. Lawlor and Mr. Conway have dealt with it.

Over and over again we have questioned in some detail the four people who are directly responsible for that here in the committee. I questioned them: Did you discuss it? Did you, as a person in the hospital responsible for that ever feel concern? Have you communicated with the minister? Have you communicated with the Etobicoke fire marshal? Have you communicated your concern to all levels?"

At no time have they expressed more than the normal concern of a professional who is responsible for the safety of a hospital. There was no message to the ministry. So I questioned, just like Mr. Conway, where you got this information and came to the conclusion that you didn't get it from those sources; that it came from who knows where.

The point is it has been disproved consistently, here in the committee, that this was not one of these—

**Mr. Jones:** We are talking about access, and why floors were closed. If that isn't a hazard as much as—it could start a fire.

**Mr. Lawlor:** He said categorically that it was not a fire hazard.

**Mr. Jones:** You also said that floors were closed and asked why there was lack of access.

[5:30]

**Hon. Mr. Timbrell:** With respect, Mr. Chairman, you have heard points of view,



such as are being described right now by the member for Parkdale. But with respect, you have heard the other side too.

**Mr. McClellan:** From whom?

**Mr. Duksza:** Mr. Minister, let me rephrase what I've said. I do not know whether the hospital is a fire hazard or not, because I have no expertise in that area. I have taken the evidence of the four people who are directly responsible in the hospitals in the Etobicoke area to be that. I say to you you have not proven your case and you should withdraw that.

The other two points you have used are that the Queen Street hospital is a modern facility—which no one denies—and it has a number of beds which should be filled.

You don't fill up the hospital. You don't abolish one hospital and combine it into one merely because there are beds to fill.

I don't know what kind of imperative it is, but almost anyone who has worked in the field of psychiatry will say to you that there doesn't seem to be a reasonable imperative to fill up a bed merely because it is there. You have to think of what to do. If a mistake was made originally, and you know it was made, if you're building four towers instead of two towers at the Queen Street Mental Health Centre, nevertheless, it's not an imperative.

The other most important reason that you have brought up for closing Lakeshore Psychiatric Hospital is that you considered that modern psychiatry demanded treatment of individuals in the community.

**Hon. Mr. Timbrell:** Some.

**Mr. Duksza:** Some?

**Hon. Mr. Timbrell:** I've never said all.

**Mr. Duksza:** Good; I'm glad you said that, because the impression was left, virtually in the direct words of your statement, that it was a forward and progressive step to close the Lakeshore so that, in effect, we would treat all our psychiatric problems in the community.

**Hon. Mr. Timbrell:** With respect, Mr. Chairman, that is absolutely and totally false.

**Mr. Duksza:** Of course it's false, because in effect you are not doing that. I agree entirely; I was just about to say that.

**Hon. Mr. Timbrell:** You know as well as I do, if you remember back to 11 months ago—maybe it was a little longer ago than that—when we sat here considering Bill 19. There were a number of occasions when you and I, and other members of the then committee, had occasion to discuss the

question of the philosophy of psychiatric care. I made it clear then, contrary to the point of view which was being proposed by some others, that the psychiatric hospital will always have a role.

The question is, do we need as many psychiatric hospitals as we have in the past? Can we provide the necessary tertiary care in other ways? That's what we're talking about here; not whether there will ever be the day when there will never be a psychiatric hospital.

**Mr. Duksza:** What you have proposed is to combine the two hospitals and create a very large institution within five to 10 years' time, with most of the patients in an extensive catchment area of up to two million people being treated in that one institution.

What I would like to deal with is what people have said—some of them were called by the committee, some were called by unions and some were called by you—in terms of what is an appropriate psychiatric treatment and what is an appropriate psychiatric program to deal with the problems of psychiatric patients.

We have listened to people from the whole catchment area, and we have heard a series of opinions expressed by concerned individuals, including the directors of psychiatric units—Dr. Mech, who until recently was a director of Peel Memorial; Dr. Cooper; Dr. Rzaicki; and Dr. Munroe—some called by you and some called by others.

There was an almost universal feeling and an almost universal expression by those people who were directly responsible for some of the people, saying this is a mistaken and dangerous idea, specifically because no account has been taken of an integrated program for psychiatric patients. I am summarizing what those four said, but they said that just to close one facility is dangerous; you are taking a risk both in terms of future demographic trends and with the patients now.

We've had a series of witnesses from the social planning agency in Peel and the volunteer agencies to the staff of the Lakeshore until, finally, we came to deal with the people from the Queen Street Mental Health Centre, who have repeatedly said—

**Hon. Mr. Timbrell:** Mental Health Ontario.

**Mr. Duksza:** Mental Health Ontario—all sorts of groups have come to us.

Interjection.

**Mr. McClellan:** The minister should read what he said some time.



**Mr. Duksza:** That's a very good point. You have very selectively read one of the five who tended to support your point of view. You probably think Dr. Roberts supported your point of view, among other things.

**Hon. Mr. Timbrell:** Not entirely, no.

**Mr. Duksza:** No, indeed, he didn't. His testimony is a very good example of maybe a tenacious nature of some of the witnesses. Dr. Roberts especially was tenacious, because he made the major statement that, in effect, you could deal with most of the psychiatric problems in the community if his system of working were accepted.

**Hon. Mr. Timbrell:** May I interrupt and ask a question, because I can't come back tomorrow? Are there any questions I can answer for you or for any of the members who are on the list?

**Mr. Duksza:** Well, before I can ask you questions, Mr. Minister, I would like to finish at least some of the—well, I mean what can I do? The minister has to either come back, or what do we do?

**Hon. Mr. Timbrell:** I am just trying to make a point. I have indicated to the chairman that I have a delegation coming at six o'clock and if the committee wants to—

**Mr. Duksza:** You want to leave in about five minutes?

**Hon. Mr. Timbrell:** I have to leave in about five minutes in order to be back in time to meet this delegation, and I wondered if there are any questions. I think you are making your arguments for whatever resolutions you may have before you tomorrow, or whenever, and I just wanted to know if there are any questions that I can answer for you while I am here.

**Mr. Duksza:** Then in the few minutes I have remaining, because obviously we will not be able to question you any more; there are a number of other people who at the moment cannot question you.

**Mr. Lawlor:** Any resolutions drawn, by the way, as yet?

**Mr. Duksza:** So if you are leaving in three minutes, all I can say is it is probably—

**Hon. Mr. Timbrell:** No, no. If you have any questions—

**Mr. Duksza:** Mr. Minister, let me tell you this; before I go into questions, I want to make a statement. Allow me this. You spoke for two hours yesterday to summarize what you have—

**Hon. Mr. Timbrell:** You had three weeks.

**Mr. Duksza:** We listened for three weeks and it would have behaved you well to listen, too, for three weeks to the other people who expressed a direct concern of what goes on in your ministry. It is this that we are now discussing; the chaotic, arbitrary nature of decisions; the inability of you and the staff at the moment to plan properly for the next 10 years; and the arbitrary nature of the decision taken in closing one significant aspect of the whole system without taking into account the effect it would have on others.

Repeatedly, psychiatrist after psychiatrist, health professional after professional, have stated that if you are going to move towards a different approach in the delivery of psychiatric care, you have to put Dr. Wasylenki, Dr. Roberts, even Dr. Durost—you need a number of years to plan a program. You simply do not close an item, a significant program of the whole psychiatric services and then hope that you will deliver, within three months, a magnificent new set of plans.

The people you have appointed to those committees, what else can they do except try to clean up the act of your cutting off the significant section of the psychiatric service? They can only clean up.

**Hon. Mr. Timbrell:** How can you make that point when the impatient programs will be transferred in their entirety and carry on? The outpatient programs that exist will carry on indefinitely, as it were, until such time as alternatives are found and the new community mental health programs will start up—

**Mr. Duksza:** Well, let me just respond, Mr. Minister, I say to you, as the Minister of Health, you do not understand what is modern, what is orthodox, in psychiatric care, which is small hospital based and delivering care for a community-based psychiatric service. You are now denying the nature of what you have said, that this was a progressive movement. You are merely combining the two hospitals into—

**Hon. Mr. Timbrell:** Mr. Chairman, as the honourable member knows, anything I have read—and I am not learned in medicine, let alone psychiatry like the honourable member, although I am aware not even all psychiatrists agree with the honourable member. The fact of the matter is that what we have and what we support and what we are pledged to continue and foster, is a system that provides for tertiary care in the provincial psychiatric hospitals; the continued development of community psychiatric units, and the continued development of community mental health programs.

**Mr. Duksza:** You are indeed, Mr. Minister, pretentious, intemperate, not understanding of what a psychiatrist is about in psychiatric services. You respond to the imperatives of people like the finance minister. You have not been supported in terms of planning for the future 10 years, by the people who are experts; you have rejected your own experts.

I don't understand how you can actually go on at the moment and be so totally temporary orientated, without thinking at all what will happen in five or 10 years' time to the psychiatric needs of the people for whom you are now responsible. I sincerely hope you will not be responsible for long, but you are now responsible for it and you have not taken care of providing the care for the next 10 years.

You are thinking now only of saving \$6 million—by the way, if we have time to examine it I wonder if you will be able to save anything since clearly, the way Mr. Lawlor has been able to point out, more and more things will be remaining. So I don't even know whether you will be able to save anything at all. The whole thing has been completely unplanned. Answer that. It was probably thought out in the middle of night when you couldn't sleep and you thought, "Let's close Lakeshore." By the way, it is very typical.

**Hon. Mr. Timbrell:** Mr. Chairman, the honourable member would appear to be a better fiction writer than he is a member when he makes those kind of ridiculous, wild statements.

**Mr. Duksza:** Mr. Jappy, who is one of your advisers, a year or so ago said one hospital had to be closed and it didn't really matter to him which hospital it was.

**Hon. Mr. Timbrell:** That is not true, and the honourable member should withdraw that scurrilous remark.

**Mr. Duksza:** No, I will not withdraw it.

**Hon. Mr. Timbrell:** Well then, let it stand to your discredit.

**Mr. Kennedy:** The members are most passionate this afternoon.

**Mr. Duksza:** I brought the minutes of a meeting; that's where it comes from. I have the minutes of the meeting when Mr. Jappy attended and said that.

**Mr. Kennedy:** Mr. Chairman, the members who spoke this afternoon have all indicated, have all stated flatly this decision was taken without any planning, without any review—

**Mr. McClellan:** Because that's what happened.

**Mr. Kennedy:** —as if it were an overnight decision by the minister.

**Mr. McClellan:** Which it was.

**Mr. Kennedy:** I think that is not correct. It is right in the minister's statement of January 22. The initial draft of the report was received in September 1977, and the final report in January 1978; more than a year ago.

**Mr. R. F. Johnston:** That's McKinsey.

**Mr. Kennedy:** Our review was well underway when it was overtaken by budget considerations. To me, that review means some planning was done. It has been left in this committee this afternoon that it was an overnight decision by the minister without any planning, without any review.

**Mr. McClellan:** It was an overnight budgetary consideration.

**Mr. Kennedy:** I think the minister should take a moment and clarify that point.

**Mr. Lawlor:** Mr. Kennedy, you are talking about the McKinsey report.

**Mr. Kennedy:** I am talking about the decision that was made following that.

**Mr. Duksza:** Mr. Minister, there is one thing I have to clarify here.

**Mr. Kennedy:** There was well over a year when that was before the ministry; and I want to clarify that, Dr. Duksza.

**Mr. Duksza:** Yes, but I want to clarify what I said about the ministry, as expressed by Mr. Jappy, is not invented by me. It comes from the minutes of a meeting he held—and I can read you the whole thing—in 1977 when you met with union representatives in Penetanguishene. You have expressed that feeling in general terms, and that is where it comes from.

**Hon. Mr. Timbrell:** Could I have the minutes please? Were these shown to Mr. Jappy at the time so he could attest he agreed with the minutes?

**Mr. Duksza:** I am showing them to you now.

**Hon. Mr. Timbrell:** No, well I am asking was he shown these minutes?

**Mr. Duksza:** I don't know. I don't work in your ministry.

**Mr. Pope:** Who kept them?

**Mr. R. F. Johnston:** You would have to look at the ministry's record of the meeting.

**Mr. Duksza:** The criticism at the moment is towards you, Mr. Minister, because you are responsible, not Mr. Jappy. You are responsible for the provision of psychiatric services. You have not taken care of the orderly



provision of forward-looking psychiatric services.

**Hon. Mr. Timbrell:** Mr. Chairman, it will surprise no one that the honourable member would have that point of view. I tell you I feel very strongly that given all of the factors with which a minister must contend that what we have come up with is, in fact, a plan which will provide quality psychiatric services for this population, looking ahead to the foreseeable future.

**Mr. Lawlor:** You are making a very great mistake. Why don't you have the grace to admit it?

**Mr. R. F. Johnston:** The psychiatric community wasn't expecting it, and you turned it right around. They were expecting the McKinsey report, as Mr. Kennedy says.

**Hon. Mr. Timbrell:** Were there other questions? That's what I was trying to get at before I have to go.

**Mr. Sweeney:** Can I ask one? It would appear there is some possibility that seven or eight years down the line a hospital may be needed in the Lakeshore area, even if it is not needed today. Will the retention of the land be of such a nature that could be done? Is the land going to be retained and then parcelled up so if you need it in seven years you can't do it?

**Hon. Mr. Timbrell:** No, it will be retained. I would say that if in seven or eight years—to use your time frame—it was determined there was a need for additional space, it might not necessarily be on that site. Given its catchment area, it could well be somewhere else in the catchment area, depending on the distribution of population at that time.

**Mr. Vice-Chairman:** We just have one member left on the list.

[5:45]

**Mr. R. F. Johnston:** I'll ignore all the questions I had. I did have more, I want you to know that, but I want to just ask about jobs at this point.

You are saying in point of fact that there will be pretty substantial outpatient services there for the meantime until we know what is transferred to where in the community and that sort of thing. Have you talked to the union about the security of jobs for people who are planning to sell their homes and leaving and that sort of thing? Do you have the number it is going to affect as far as maintenance goes? Do you have any idea how many jobs will now be able to stay there that would not have been able to stay there before? Have you done any projections of that sort of thing?

**Hon. Mr. Timbrell:** I would like Mr. Jappy to comment, but I am just noticing these minutes. I don't know who kept these minutes but Mr. Jappy tells me there was a meeting. He met with management staff there, but whoever took these minutes says it was suggested the Clarke Institute might even close. For God's sake, that is outrageous.

**Mr. R. F. Johnston:** I think that's outrageous too, but could I ask you about jobs? Rather than talking about inflammatory phrases like fire hazards and this kind of accusation, I would rather ask right now, because we have only got you for a minute, what about the jobs? There are people out there who have been support staff who thought they were leaving who may now have to stay to help out the patient services there.

**Hon. Mr. Timbrell:** First of all, any layoff notices that still exist are effective on August 31 and I would anticipate being able to get back to the implementation group, the advisory group, well before then with the results of the review and then to come up with final decisions well before then.

Do you want to comment on that as well, Mr. Jappy?

**Mr. Jappy:** We will certainly work things out with the respective administrations and with the union representatives, as we have all along.

**Mr. R. F. Johnston:** My concern in working towards that deadline is that these people have been living with insecurity now for a number of months.

**Hon. Mr. Timbrell:** We will continue to post at Lakeshore, as we have been, all vacancies in the ministry. We have the co-operation, as indicated yesterday, of the Civil Service Commission in effect freezing those categories where we have staff and redundant positions, so they get a first look-in at those vacancies.

We will continue to work with the public hospitals and they have given us good co-operation and some staff have in fact already transferred to the public hospitals.

**Mr. R. F. Johnston:** But we do know there is major insecurity and understandable personal—

**Hon. Mr. Timbrell:** Yes, and that was one of our first considerations—how to assist in that area.

**Mr. Conway:** The steering committee had met; Mr. Kennedy and Mr. Lawlor and I had roughly decided—and it is entirely open, but I will just report it for comment—that



the steering committee felt in general that there might be real value in trying to have a written report or reports, such as they were, in the chairman's hands by the time our normal mandate expired tomorrow evening. That was our general desire; I think both Mr. Kennedy and Mr. Lawlor would agree.

Once the testimony was concluded we felt that we would, either on Tuesday or Wednesday, just generally make a public comment that might be useful from each of the three caucuses as to how we saw the evidence and what kind of conclusions it led us towards to see what if any unanimous consensus or unanimous recommendation might be possible, so we weren't all going off in different directions in writing a report.

I think that is a fair representation of the way in which we thought we would proceed, rather than all come in with a written statement of some kind, working from that, although that was intended.

**Mr. Kennedy:** Well, I have written down some thoughts.

**Mr. Conway:** I know some people have jotted down some notes; I regret I haven't. I don't know how people want to proceed. We do have all of tomorrow, although there is still a requirement to have a written report—which all of us imagine to be less than

rewriting the Koran in terms of length—in the hands of the committee chairman for report to the House at the earliest opportunity after tomorrow evening. I speak very strongly on this point. I don't know how we want to proceed at ten to six.

**Mr. Lawlor:** I imagined it a little differently: each one of us tomorrow morning, when the steering committee meets, would have our basic point fashioned on what we propose. We would circulate it among the three members and hope among those members some kind of consensus might be reached. If it were not possible to do that, we could bring the matters back before this committee tomorrow afternoon, argue the points involved and strike a report as things stand there and then, and submit it to the chairman of the committee to take into the House.

**Mr. Vice-Chairman:** Are all members of the steering committee present and is that agreeable?

**Mr. Duksza:** What time tomorrow?

**Mr. Kennedy:** Eleven o'clock?

**Mr. Conway:** Eleven o'clock in the library reading room. We will each present a page or two or whatever of our conclusions.

The committee adjourned at 5:50 p.m.

#### ERRATA

No.	Page	Line	Should read
S-9	S-294	16	Roberts, Dr. C., Past Chief of Psychiatry, Royal Ottawa Hospital
S-9	S-294	17	Wasylenki, Dr. D., Staff Psychiatrist, Clarke Institute of Psychiatry

---

## SPEAKERS IN THIS ISSUE

---

Conway, S. (Renfrew North L)  
Duksza, J. (Parkdale NDP)  
Johnston, R. F. (Scarborough West NDP)  
Jones, T. (Mississauga North PC)  
Kennedy, R. D. (Mississauga South PC)  
Kerrio, V.; Vice-Chairman (Niagara Falls L)  
Lawlor, P. D. (Lakeshore NDP)  
McClellan, R. (Bellwoods NDP)  
Pope, A. (Cochrane South PC)  
Sweeney, J. (Kitchener-Wilmot L)  
Timbrell, Hon. D. R.; Minister of Health (Don Mills PC)  
**From the Ministry of Health:**  
Jappy, W. C., Director, Psychiatric Hospitals Branch  
Surplis, Dr. D. W., Special Assistant to the Minister







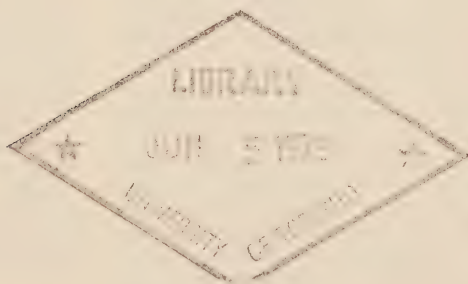
No. S-16

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Wednesday, May 16, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

WEDNESDAY, MAY 16, 1979

The committee met at 2:14 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Chairman:** I see a quorum. Before I begin, I want to read into the record the so-called permanent substitutions that have pertained in the committee for these hearings.

In place of Mr. Cooke, Mr. R. F. Johnston; for Ms. Gigantes, Mr. Lawlor; for Mr. Grande, Dr. Duksztá; and for Mr. Kerrio, Mr. Conway. Then, today, I have a substitution, Mr. Villeneuve for Mr. Jones.

**Mr. Conway:** And Mr. Van Horne for Mr. Sweeney.

**Mr. Kennedy:** And Mr. Gregory for Mr. Pope.

**Mr. Chairman:** It's a heavy week. I think we have those.

The purpose of our meeting today is to deal with the report on the closing of the Lakeshore Psychiatric Hospital, the subject of four weeks of hearings of this particular committee. From the chair's standpoint, I would hope that we could reach a consensus or at least determine the degree to which a consensus exists. It would be my hope that we can come in with a unanimous report. If we can't, so be it, but I think that should be our objective under the circumstances.

That being said, I understand that there was a steering committee meeting this morning, at which time all three parties indicated their tentative positions. I would like a report from that steering committee. Perhaps it could form a basis for a discussion. **Mr. Conway:**

**Mr. Kennedy:** Mr. Chairman, I must say that the steering committee decided that Mr. Conway would be our chairman, for the record.

**Mr. Chairman:** Oh, I see.

**Mr. Kennedy:** So, if you would ask our chairman to report.

**Mr. Chairman:** As chairman of the steering committee?

**Mr. Conway:** Thank you very much, Mr. Chairman. The steering committee did meet this morning for a time. At that time, each of the members presented a written document

which represented the beginning position—at least the beginning position—of each of the three caucuses. What I think might be useful would be simply to have distributed the initial statements by each of the three caucuses.

I have, on behalf of my colleagues, distributed our initial position on one plain sheet. I know the other two initial positions are available. It might be useful, since not all members will have seen all initial statements, to have those copied and circulated. At that point, we can begin to discuss areas of agreement and other areas. I think, Pat, that represents it fairly.

**Mr. Lawlor:** That's fair enough.

**Mr. Conway:** I think everyone should have a copy of one page of the Liberal members' statement and Mr. Kennedy I know has—

**Mr. Kennedy:** Here, pass that over to Mr. Lawlor. He is getting an extra copy. And Mr. McClellan needs an extra one.

**Mr. Chairman:** Is it the wish of the committee that we read through the initial position papers of each of the parties? I think it would be preferable to have the report from the steering committee which, I gather, would represent a consensus of the three documents.

**Mr. Conway:** Mr. Chairman, the committee did discuss areas of common ground. I think we reached some conclusions. For example Mr. Kennedy might wish to comment on his initial statement; there were six points. I think I fairly represent the steering committee when I say that on points four and six there was agreement on all sides that, "this committee recommends to the Ministry of Health that every assistance in finding alternative employment be given to the employees at Lakeshore Psychiatric Hospital who are scheduled to be laid off." And on point number six, "that this committee endorse the decision of the government as stated by the Ministry of Health on April 23, to retain the Lakeshore Psychiatric Hospital site in public ownership." On those two points, there was complete agreement in the committee, as I understood it, on points four and six.

There was a discussion in the steering committee with respect to points two and three on the Liberal list of recommendations. There was clearly a desire to review the language



in those two recommendations. I think Mr. Lawlor and Mr. Kennedy might agree there did seem to be some area of common ground that there were unanswered questions or certain concerns about language which it was felt would be more properly dealt with here.

I regret, Mr. Chairman, that beyond that we did not make any further recommendations.

**Mr. McClellan:** Just to clarify, what we've been given by Mr. Kennedy is a combination of the Liberal and Conservative decisions?

**Mr. Kennedy:** That is correct. When we came together as a steering committee we found that the first three points in the Liberal combined as our primary point endorsed the decision to remove the inpatients as scheduled. Our second and third paragraphs, which I am sorry weren't numbered, endorsed the retention of existing outpatients' services and the expansion. That seemed to turn out to be combined in what is the second point in the Liberal position.

I should point out that I had this retyped combining the two. Being fully aware of it, I took out at the title "Recommendations of the Liberal Members" to make it "Recommendations of the Social Development Committee Regarding Lakeshore Psychiatric Hospital," in case that would be acceptable to the committee—and in fact that's what the whole report would turn out to be.

Now to go on, point three requested an independent survey be undertaken within two years. The Conservative position had made reference to five to 10 years' time, but we went along with their two-year recommendation, their point three.

Then, as Mr. Conway mentioned, we included paragraph four, which was to do with the employees, and the final one was the retention of ownership.

Those are before us then, Mr. Chairman, if there are any questions of clarification needed.

**Mr. Conway:** Mr. Chairman, the committee did deal with the point by point presentations and we just tried to get some tentative understanding of whether or not there was any measure of agreement. These are purely working papers, of course, for this committee to exercise its more collective judgement on report or reports such as they may.

**Mr. Chairman:** Is it the wish of the committee then that the steering committee report form the basis of our discussion this afternoon, which would be subject to amendment or alteration as the committee wishes?

**Mr. McClellan:** The difficulty is, Mr. Chairman, the steering committee report only re-

flects two of the three positions. It does not reflect the position of the New Democratic Party in a major respect, that is to say with respect to the retention of inpatient services at the Lakeshore Psychiatric Hospital. My sense is that will be the issue to which we have to address ourselves.

**Mr. Conway:** Yes, there was a measure of discussion on that and a difference of opinion was clearly apparent.

**Mr. McClellan:** An important omission from the chairman's report of the meeting of the steering committee.

**Mr. Lawlor:** Mr. Chairman, I take it the New Democratic Party statement is available and distributed now, is it? I want to make one change immediately. If you will look at page four, down five paragraphs, the paragraph that begins, "We believe that it is imperative that a full systems study of the mental health needs of the greater Metropolitan Toronto area be begun, completed and evaluated before any decision is made to terminate an integral element of the existing network of psychiatric services." I want to put in there "and this study will be completed and made public within six months." Our position being basically that we don't think this committee is going to have a great impact, except for some refinements with respect to the outpatient situation.

The rub is, of course, with the inpatients. We'll hear some argument pro and con, I trust, with respect to that. We wish to retain the inpatient population at the hospital pending a clarification and a further review of the situation, arising out of the McKinsey report and its indications, and the evidence that we have heard for the last four weeks.

We believe that it is not that clear, there are too many ambiguities and the consequences are too dire to make the move. We believe, as I believe the Liberals and the Conservatives do on the basis of their statements now, that an independent study certainly is necessary. By "independent" we really mean independent. It's a question of the timing of that particular report. If it's a two-year period—I don't want to put words in the mouths of the Liberals but I think they think that's too long a period in which to place the Lakeshore situation in abeyance, and I don't think a two-year period is necessary to make this review. I think it can be completed adequately within a six-month period, given the very great amount of information already available in this regard, what we've been able to dredge up in the past period of time.

That in any case is our proposal in that particular area and it does modify our statement somewhat.

**Mr. Chairman:** I gather then that there is consensus on the matter of maintaining the outpatient facilities at Lakeshore. As far as the committee is concerned everything then turns on the matter of what this committee is prepared to recommend in terms of dealing with the inpatients in the hospital. Is that a fair assessment?

**Mr. McClellan:** I have one proviso, however, with respect to the wording of the Liberal-Conservative recommendations around the outpatients and I want simply to recall to mind that the commitment of the minister at the time he announced the closure. His commitment was that the outpatient services would be maintained and enriched, and the enrichment has been omitted from the Liberal-Conservative recommendations. I would hope at the least that they would not backtrack from the minister's own miserly concession, and would include the phrase "continued and enriched" in place of the phrase "continued at least at the level . . ."

**Mr. Chairman:** Let's get the outpatient part out of the way first. Would that be agreeable to the committee? I think that's the point at which we can reach consensus quickly and then we can deal with the inpatient matter. **Mr. Kennedy?**

**Mr. Kennedy:** I was going to agree with that point. The second sentence of paragraph two says "maintain and improve", and you could add "and enrich" there. I certainly have no quarrel with that. **Mr. Chairman,** you mentioned that you interpreted this as saying the services would remain at Lakeshore. This isn't quite accurate in that if there can be an upgrading of services by retaining some flexibility this is what our desire is, as is stated in that point. I wanted to make that clear.

**Mr. Conway:** On **Mr. McClellan's** point I want to indicate that, yes, there is absolutely no question that it was an unfortunate assumption that we just proceeded on, and making that a specific part of the language is a good point on which I am very happy to agree. Ross, if you want to, just as a working item, amend point two by recommending that these community services continue, your phraseology was, I thought, excellent. Will you repeat it?

**Mr. Chairman:** "Continue and be enriched, at least at the level."

**Mr. Kennedy:** I have a suggestion. **Mr. Chairman,** try this one for size. I am not going to try to improve the wording myself.

I will leave that to you gentlemen. How about going this way in the fourth line where it starts, "These community services not only continue at least at the level they were prior to January 22, 1979, but be enriched, and that no administrative difficulties . . ." Would that answer the question?

**Mr. Chairman:** That conveys the idea you were expressing, **Mr. McClellan,** does it not?

**Mr. McClellan:** I think so, yes.

**Mr. Kennedy:** I assume, and I want to make it clear for the purposes of the record, that you gentlemen are talking about all of the outpatient services, including those that are partially within the jurisdiction of Community and Social Services.

**Mr. R. F. Johnston:** And those which have inpatient components to them.

**Mr. Grande:** The term "expanded and enriched" should be used.

**Mr. Chairman:** "But be expanded and enriched"?

**Mr. Grande:** Expanded and enriched.

**Mr. Chairman:** Agreed?

**Mr. Conway:** All right, so it will read then?

**Mr. Chairman:** It will now read:

"In that there is a clearly demonstrated need to maintain and improve the outpatient services presently connected to Lakeshore Hospital, we recommend that these community services continue at least at the level they were prior to January 22, 1979, but be enriched and expanded and that no administrative difficulties associated with the transfer of inpatients be permitted to interfere with the achievement of this goal." Is that acceptable?

**Mr. Leluk:** That doesn't quite read well.

**Mr. Kennedy:** You need "not only".

**Mr. Chairman:** "Not only", I am sorry.

"These community services continue at least at the level they were prior to January 22, 1979, but not only—"

**Mr. Leluk:** "These community services not only continue," fourth line, and then "but."

**Mr. Chairman:** "Not only," right. Okay, so that it would now read in the third line:

"We recommend that these community services not only continue at the level they were prior to January 22, 1979, but be expanded and enriched and that no administrative difficulties associated with the transfer of inpatients be permitted to interfere with the achievement of this goal."

**Mr. Van Horne:** **Mr. Chairman,** I have a grammatical point. It is "not only," "but



also," if you are going to use the proper sentence.

**Mr. Lawlor:** I have some difficulty with that last clause "and that no administrative." The wording was "bureaucratic" and I thought it was perfectly pertinent, but Mr. Kennedy doesn't like the term, so we changed it to "administrative"—I guess we did, didn't we?—"associated with the transfer of inpatients be permitted to interfere with the achievement of this goal," and I found that ambiguous. I didn't quite know what it meant.

**Mr. Conway:** Well, it is a difficult sense to convey, and I will repeat it. I think the member for Scarborough West, in an aside a few moments ago, really anticipated a part of the problem, that there are administrative bureaucratic mechanisms by means of which staff are allocated on the basis of overall inpatient capacity and rating, and that if we phase out the inpatient capacity at Lakeshore, we do not want that to impinge in any way upon the outpatient services that existed there prior to January 22. It is anticipatory in a sense because I don't envisage all the actual situations in which the loophole could be used.

If someone can deal with that more effectively—we felt that we wanted it included because we are accepting that there would be a transfer of inpatient capacity out of Lakeshore. In that connection we don't want that to be used administratively, or otherwise, to cut into outpatient services, some of which will have some measure of inpatient commitment that existed prior to January 22. I will admit it is not the most precise language, but I couldn't offhand and quickly work up anything that was—

**Mr. McClellan:** There is another report which more adequately deals with both the problem and the solution. However—

**Mr. Conway:** Well, I recognize that, and I don't take it lightly. We do have a—

**Mr. McClellan:** The difficulty is, of course that you are truncating programs, you are cutting programs in half.

I speak specifically, for example, of the industrial therapy program which was set up and designed to serve both inpatients and outpatients. Now we know from our visit to Queen Street that the Queen Street industrial therapy program cannot accommodate the additional inpatients who will be transferred from Lakeshore. We know, as well, that some skeleton of the industrial therapy program will be maintained at the Lakeshore site. That was one of the concessions the minister announced to us hastily this week;

I gather it was arranged over the weekend. As far as I am concerned, it leaves the whole program in a state of enormous confusion.

What is the capacity of Queen Street industrial therapy program to absorb the additional acute patients at Queen Street into its facility, et cetera, et cetera? I don't have to belabour it. As far as I am concerned, it speaks to the inadequacy of trying to separate inpatients and outpatients to say, as you are saying, Sean, that the inpatients can be moved over to Queen Street. I don't happen to believe that that can be done without enormous damage to people.

**Mr. R. F. Johnston:** The point I was trying to raise was exactly that. I notice that the member for Scarborough West was being drawn into this, and I want to say very clearly that I think that the move of inpatient services in general from Lakeshore cannot but effect the quality of outpatient care that we are talking about here.

I understand what is being said in this particular phrase, but I also think it is meaningless in the general term. If the inpatients are moved, there is absolutely no way that that does not interfere with the quality, in my view. I think that has been shown to us by witnesses, and I am very distressed that certain members who seem to have spoken very strongly yesterday, and included inpatients in their very strong statements, would now today not see that as being just as essential.

**Mr. Conway:** I recognize the comments that are being made, and I suppose in an abstract sense, if we are here to determine the ultimate strength of our position we can do so. I am not unmindful of what members are saying. As a group we certainly have been concerned with the way in which this whole procedure has occurred. As someone who had a lot to do with the phrasing of our recommendations I faced a government decision which was proceeding and is almost certainly likely to proceed. Against the comments that have been very eloquently put by the honourable members opposite, I think of the other and countervailing point which would be holding a substantial number of inpatients hostage, in a sense, when indeed it is clear they can be moved and provided with a much better institutional framework in terms of plant.

**Mr. McClellan:** Why don't we enter into that debate? I think that that would be useful to do, since the issue of consensus revolves around this split between outpatients and inpatients. Maybe we could have some discussion and see if it is possible to return the Liberal Party to their position of yesterday.



**Mr. Conway:** Well, if it is thought useful. I just want to be clear. As far as I am concerned, the position that we have adopted is quite consistent with what I have said throughout. Indeed, as I listen to certain members opposite now say that inpatient facilities are the paramount concern, it seems, to my ears at least, highly contradictory of what was said, or of an impression left earlier. But indeed, if the member for Bellwoods wants to engage in a debate on that—

**Mr. Lawlor:** I don't know how that impression was ever left.

**Mr. Chairman:** I think it's really counter-productive to try and assess one another's positions as of yesterday or the day before, or last month. What we're here to do is to try and reach a consensus if possible on writing this report. If the committee feels that a discussion around the inpatient facilities and the need to maintain them at Lakeshore, or otherwise, would be useful in ultimately arriving at the outpatient part of the report, then I'm quite prepared to allow that discussion to go forward at this point. Is it the wish of the committee that you do it in that fashion?

**Mr. Conway:** With the one caveat, if I might: that if we appear to be unable to reach a consensus—and a consensus is no great goal of mine; it's preferable, but it's not necessary—that I want to be clear, from my party's point of view, that there is no difficulty whatsoever on our agreeing to disagree, and to issue three separate and independent reports.

**Mr. Dukesza:** Not three separate—two of you and one of us.

**Mr. Conway:** No. But I want to make it clear to the member for Parkdale and other members that our position is the one-page document I have circulated to you that does contain three specific points—

**Mr. Dukesza:** You spoke about them in the last two days.

**Mr. Conway:** —some of which you may be interested in, and some of which you may not.

I just want to repeat, Mr. Chairman, that it is not my intention, or the intention of my colleagues, to waste your time or the time of other members in pointless debate. We certainly think that there may be some constructive debate possible, but if there is not, we certainly can live with the issuance of a report which consists of three separate and independent points of view.

**Mr. Dukesza:** I agree with you, Sean. I have nothing against that. Yours is in a majority, and ours is in a minority.

**Mr. Chairman:** Mr. McClellan and then Mr. Lawlor.

**Mr. McClellan:** I'd like to speak for a few minutes to the issue of the inpatient services, if I may.

**Mr. Lawlor:** Before we come to that—this is on a kind of technical point as to how we go forward. The Conservatives have recently revamped their statement that we saw earlier; they have accommodated and brought into their statement precisely what you recommended in the steering committee. Therefore, Mr. Chairman, can't we deal with the later Conservative statement? Do the Liberals accept that as being representative of their position, too?

**Mr. Conway:** Do you, Mr. Lawlor, accept points four and five as items you agree to, so that to that extent that two-page, five-point document represents, in part at least, a consensus arrived at by all three members of the steering committee two hours ago?

**Mr. Lawlor:** That is correct.

**Mr. Conway:** Let us be very clear in stating that this is a Liberal-Conservative point of view, when it's understood by me at least that it is a document which reflects, in part, positions agreed—

**Mr. Dukesza:** Not the documents, just the last bits of it, Mr. Conway.

**Mr. Conway:** That's almost nominalistic.

**Mr. Dukesza:** No, it's not nominalistic. We're in fundamental disagreement—

**Mr. Conway:** It is clear that the steering committee did agree on all sides to certain points in that. To that degree it is not a two-party agreement, in some respects it is an all-party agreement.

**Mr. Dukesza:** I think we should face it. I have no objection to majority and minority opinions. It's part of the coalition.

**Mr. Lawlor:** Mr. Chairman—

**Mr. Chairman:** Mr. Lawlor, the point you were raising, sir?

**Mr. Lawlor:** The point I was raising: can't we discuss one document here as representing a position that both Conservatives and Liberals accept and go from there? I don't have to refer to anything else.

**Mr. Kennedy:** Mr. Lawlor, we have these five points put together, true, and we've made a small amendment at the suggestion of the NDP to paragraph two. It was my hope, at least, that all members might agree to paragraphs two, three, four, and five, which doesn't impose itself or isn't in conflict with the NDP position paper. If you'd consider points two, three, four, and five in conjunc-

tion with yours, if you want to go on from there, that's another matter.

[2:45]

**Mr. Chairman:** We were up to one—

**Mr. Kennedy:** Maybe our paths diverge.

**Mr. McClellan:** They've diverged before.

**Mr. Chairman:** Just on Mr. Lawlor's point. I thought what we were attempting to do, initially, was move through this document as advanced by the steering committee. It lists five points. We got down to point two and Mr. McClellan said there's no point in engaging in a debate with respect to outpatients until we have the inpatient matter settled.

At that point, the discussion on the steering committee papers ceased, and we then entered into a discussion as to whether we should move away from discussing outpatients and talk about inpatients.

**Mr. Lawlor:** It's not the steering committee paper that you're talking about. It's a Conservative redraft. It's not a consensus paper. It does embody the basic Liberal objections, rising out of their paper.

**Mr. Conway:** Point of order: I would agree entirely. The paper does not represent the report of the steering committee because to the degree that there was a meeting there was no determination to issue a written report of that meeting. But as Mr. Lawlor has pointed out, and as I will quickly acknowledge, in his redrafting of the positions, Mr. Kennedy has, from our point of view, very fairly represented what is clear from our initial document. He has added to that points four and five, to which there was general and quick agreement in the steering committee.

**Mr. Lawlor:** If you speed up this discussion—

**Mr. Chairman:** All right. So this paper is what I will now refer to as the Conservative redraft, is that right?

**Mr. Conway:** That's fair.

**Mr. Chairman:** All right. Is that redraft, as it is, acceptable to the committee, at which point we can go on to something else?

**Mr. McClellan:** No.

**Mr. Lawlor:** No, it's not acceptable. Now I think we should launch into the inpatient thing.

**Mr. Chairman:** Now we'll launch into the inpatient thing.

**Mr. Kennedy:** Couldn't we, Mr. Chairman, ask Mr. Lawlor if any of the paragraphs are acceptable?

**Mr. Duzshta:** But we can't discuss it on aspects. The next thing, you'll want to know

whether we accept a comma or a full stop.

**Mr. Kennedy:** No, I disagree with that.

**Mr. Duzshta:** You either discuss thematic-ally or you don't.

**Mr. Chairman:** Well, obviously, we're getting nowhere fast, here. I think—

**Mr. Conway:** If I might add a personal view, I do detect a substantial difference in tone and attitude, at least, which is not unexpected. I would move that the Conservative redraft be set aside and that there be simply a report to the House, issued by you, at the earliest and appropriate opportunity, incorporating the three positions of the three parties as those parties put those positions in your hand, at or about five or six o'clock this afternoon.

**Mr. Chairman:** Is that a motion, Mr. Conway?

**Mr. Conway:** Yes. It is a motion.

**Mr. Duzshta:** Can I speak to that?

**Mr. Chairman:** Dr. Duzshta.

**Mr. Duzshta:** No, I don't think we have come to the point where we have to have a report which separates this committee into three parts, if there is a significant concordance between the two positions. I think the committee should work towards a report which is a majority report, and a minority one. That has happened before. It doesn't particularly upset me, nor will it upset me. But there is—

**Mr. Kennedy:** You haven't given any indication at all. You can't even agree to the item that we help those who will be laid off.

**Mr. R. F. Johnston:** You're getting rid of the inpatient program, which we disagree with.

**Mr. Kennedy:** That's item one in the draft. Why don't you talk about it?

Interjections.

**Mr. Chairman:** Dr. Duzshta has the floor. Now we've got to maintain some kind of order here, and obviously there are strong feelings on all sides. If members want to speak, they go through the chair. Dr. Duzshta.

**Mr. Duzshta:** I have nothing more to add, except that I think we should continue working from the main theme, which is whether Lakeshore remains open or not, and develop subsidiary themes from that major theme. If there is a disagreement on that major theme, then there should be a majority report—if there is a majority—from the committee, which states that the Lakeshore should be closed. Then the provisions to protect some of the aspects of it. But it's the wrong way



of approaching it for a committee to have three reports. There should be one report from the committee and a minority report if there is a minority. That's what I imagine would occur.

**Mr. Conway:** I would like my question put.

**Mr. Duszta:** Excuse me, Mr. Conway, you can't do that—

**Mr. Chairman:** You can't cut off the discussion to that extent, Mr. Conway. There is a motion and members have indicated they wish to speak to it. Mr. McClellan, Mr. Kennedy, Mr. Lawlor and Mr. Johnston. I surely can't cut that discussion off.

**Mr. McClellan:** I still wanted to talk to the issue of closing the inpatients services, which I suggested we discuss about 25 minutes ago. I think it is the crux of the issue. It relates, I think, to Mr. Conway's sense of the impossibility of achieving a majority report or a consensus report. I am not prepared to concede there is no possibility of writing a report before we have even been able to have a discussion on it, which is the implication of the—

**Mr. Kennedy:** You have a draft now.

**Mr. McClellan:** I don't accept the draft, my friend. There is a report which reflects our position. It is the draft report from the New Democratic Party. It speaks to the issue of retaining inpatient services at Lakeshore. I won't go on at length, but I would like to make the case in the hope that I can persuade my Liberal colleagues to, if I can quote directly, adopt the position that Sean Conway outlined yesterday in the committee.

Mr. Conway said yesterday, and I am quoting from Hansard, when he was talking to the Minister of Health:

"I want to tell you that I expect that we will revise your position substantially on both the inpatient and outpatient aspects, and that we will make a report to this House that I fully expect you and the government will accept in most if not all of its direction."

**Mr. Conway:** Absolutely.

**Mr. McClellan:** Absolutely. We have heard evidence, Mr. Chairman, from a huge number of witnesses; and in over 1,000 pages of transcript, most of the witnesses, most of the medical witnesses, spoke to the issue of the capacity of the Queen Street Mental Health Centre to absorb an additional inpatient load.

We have abundant and overwhelming evidence that Queen Street Mental Health Centre is, at the very best, problematical; whether it can handle the increased load in the short run. Many witnesses felt that it was impossible for them even to handle the additional inpatient load in the short run. A

majority of witnesses testified before us that on medical grounds it was impossible for them to handle the increased inpatient load in the long run.

Let me run briefly through some of the evidence. Dr. Bond, the medical director of Lakeshore, said it would be retrograde to turn Queen Street into a very large institution. He said it would be more expensive to close the Lakeshore Psychiatric Hospital. Dr. Bond told us the total institution the Ministry of Health is planning for Queen Street would serve an area the equivalent of three Norways.

Dr. Olsen, the director of outpatients at Lakeshore, warned us of congregation of people in the downtown area, because of their need to be close to this new total institution at Queen Street, and the kind of disruption that would result in the neighbourhoods downtown. Dr. Olsen told us that the \$1.3 million and the \$1.6 million are not adequate to provide needed outpatient services. She is the director of outpatient services. She is the director of outpatient services at Lakeshore.

Mr. Fisher supported the move of inpatients into Queen Street solely on the basis of unsubstantiated optimism. He had no basis in fact to assume that they could accommodate the increased load aside from a relatively vague optimism that they would be able to deal with it.

I am quoting Dr. Durost, the medical director of Queen Street Mental Health Centre from page 75 of Hansard on May 2: "I don't think it is possible to absolutely rule out the possibility that Queen Street will develop an overcrowding problem." On page 55 of the same transcript, he said, "As medical director, if I had my druthers I would sooner be medical director of a 300- or 350-bed hospital than medical director of a 600-bed hospital."

He said that he agreed with Anderson and Wasylenko that "a generous infusion of funds is needed," in order to accommodate the increased load on Queen Street. That's not forthcoming; there's not the slightest shred of evidence that that is forthcoming. Dr. Durost is one of the two people the ministry brought before us as witnesses in support of the moving of inpatients to Queen Street, and he was equivocal about their capacity to deal with it.

Dr. Anderson, the director of Southeastern Services, was not equivocal at all. He said, on page 17 of the May 2 transcript, "I can see the place nosedive as a result of a rather short-range saving, and in the long range it could be disastrous." On page 16, May 2, he said, "My experience with Queen Street



having been my total professional career, I am very fond of the place. I am afraid it is going to go downhill in terms of its ability to meet the needs of its patients."

What kind of a game are we playing if we ignore evidence like that from dedicated medical professionals at their own institutions? They are warning us that there could be disaster. Are we prepared to shrug that off? Are we prepared to do as Mr. Richardson of the Canadian Mental Health Association has suggested—well, I guess to be fair, I was the one who suggested we were playing Russian roulette with mental health patients. But it was in response to his statement that "the blood of the mentally ill will be on our hands" if this doesn't work too well. We have medical professionals warning us of a disaster.

Dr. Anderson warned us that it was a myth that community psychiatry could save money. He said: "I don't see the commitment on the part of our present ministry to spend the bucks to put alternative services in place." He warned us what would happen to patients in the psychogeriatric ward if it was expanded to 100 beds. I want to remind the members of the committee what he said.

You will recall that those wards PG5 and PG6 were built for 50 patients. He said it was unfortunate that they had been built for 50 patients. They are now at capacity, in his view, with 34 patients. Quoting from the transcript, when I asked him what kinds of problems you get into, once you surpass acceptable levels of capacity he said, "Would it be enough to say that elderly, emotionally disturbed people are incontinent a lot of the time?"

Those are the implications of moving the inpatients into Queen Street. I don't understand how we can take that kind of gamble; I simply don't understand it. Dr. Anderson said, "The crux of the thing is overcrowding after a year or two, as I see it, and no confidence that alternative methods will meet the need."

Other witnesses talked about the inadequacy of the ministry's so-called commitment to alternate facilities in the community. Dr. Wasylenki, staff psychiatrist at the Clarke Institute, said, "If the intention is to close this hospital and to replace it somehow by a co-ordinated system of community care, then one of the very important elements in that system would need to be chronic home care. I think we need it very badly. It's relatively easily implementable and it only awaits funding."

[3:00]

Well, it has awaited funding for a long time, Mr. Chairman, and there's no commitment on the part of this government to provide chronic home care on a comprehensive basis. We still have pilot projects operating in a couple of communities, but no commitment to provide a comprehensive service of chronic home care, nothing in the budget, no plans. It is simply not going to be done.

Dr. Wasylenki told us that the \$1.3 million wasn't enough. He talked about the lack of housing in the community. There are no moneys in the budget for an adequate system of community residential facilities for the mentally ill in the community. They live in flop-houses. They live in slums in south Parkdale. Dr. Dukszta says they live in the back wards of our residential areas. They have been moved out of the back wards of the hospital and put into the back wards of slums.

That's all we have in place in this province. There are no plans and there is no budget on the part of the Ministry of Health even to assume responsibility for providing decent accommodation for the people who are already there.

We had testimony from a Dr. Roberts in Ottawa, and I don't intend to go on too long for people in the committee who are looking apprehensively at the clock. I won't be more than another 10 minutes but I do want to run through this evidence because I don't see how anybody can ignore it. Dr. Roberts was one of the main ministry witnesses testifying to the advantages of closing the hospital and he started out by lauding the virtues of his own community's psychiatry program in Ottawa. He told us that Royal Ottawa is a community psychiatric hospital, that we didn't need places like Lakeshore for inpatients. Well, then it turned out that what Dr. Roberts does in Ottawa in his marvellous little community psychiatric hospital is ship five to 10 per cent of his patients every year off to Brockville and put them in the wards in Brockville. He has 300 patients from his marvellous community psychiatry program in Ottawa in the public psychiatric hospital in Brockville. So much for community psychiatry in Ottawa. All he does is shuffle the people he can't deal with off to a place 100 miles away. He finally admitted to Dr. Dukszta, and I am quoting from page 40 of the transcript: "We don't have the resources to provide community care." So much for the apostle of community psychiatry.

I think all of us remember Jerry Cooper's testimony, in summary: "I feel that if any-

thing rather than cutting beds we should be adding beds." Dr. Mech, chief of psychiatry at Peel Memorial Hospital, gave no support to the closure and again I am talking about the transcript:

"What has been of concern to us in that Queen Street is not going to be able to have any buffering beds. They are going to admit every single patient into every single bed they have. It is very well known that you probably need about 15 per cent of empty beds to allow for unpredictable fluctuation in admission rates. I think that what will happen is that a number of patients who should really be treated most efficiently, will be treated less efficiently by being discharged into the community."

Is that what we want to do, Mr. Chairman? Do we want to see people being treated in less than an adequate way and discharged prematurely into the community, as Dr. Mech who is chief of psychiatry at Peel Hospital is warning us? Are we prepared to take the consequences for that? Are we prepared to take the consequences of discharging mentally ill people prematurely back into their communities? Do we understand what those consequences are?

I dissociate myself from those of you who may want to take that gamble. I am not prepared to take that kind of gamble either with the mentally ill or with people in our communities. Dr. Mech said that we feel great trepidation about the closing of Lakeshore because we know that there will be a shortage of the type of beds which could not possibly be provided in a general hospital and for the type of patient who cannot be treated because of financial considerations, and he went on to say that even if we had \$10 million available, we still could not provide adequate care to our patients during the next—let's be conservative—two to three years.

Dr. Munroe, chief of psychiatry of Toronto General Hospital, said that the timing is injudicious. He said that it would take five years or 10 years to set up the kind of replacement facilities that are needed.

Dr. Rzakdi, chief of psychiatry at Etobicoke General Hospital, said on page 90 of the transcript: "We will always require the backup of a hospital like Lakeshore." To Mr. Leluk, he said: "I think that the \$1.3 million could very easily be used to beef up deficient services that existed before the announced closing of Lakeshore."

There were other witnesses. I won't go through the whole list. As I said, there were a thousand pages of evidence. The union presented what I thought was a very com-

elling case, that there weren't as many beds at Queen Street as the ministry was making out. They presented chapter and verse, a very detailed itemized account of the reality at Queen Street, that there weren't in excess of 200 beds that could be made available. In effect they supported what McKinsey was saying, that you could make space available at Queen Street but only with the result of dislocating programs and that most of the beds that the ministry is claiming to make available are what McKinsey had called "difficult beds."

We had the letter from the medical advisory committee, a kind of a *cri de coeur* to the committee, written in desperation. I am sure they realize the implications of writing that letter. Those people are career civil servants. You don't write those kinds of letters lightly. It is unfortunate, as Sean Conway said yesterday, that the ministry summoned them to a meeting the morning before they were to appear at this committee. I think the purpose of that meeting was clear and was achieved, but the letter is there and it speaks eloquently for their fears and concerns about deterioration of the quality of care within Queen Street mental health centre.

I go back to the beginning. There is not a shred of evidence that has been presented to this committee critical of Lakeshore. All of the witnesses said it was an excellent facility. One of the witnesses—I forget who—said that they were so excellent in fact that they were being punished for their excellence. The reason that they were being shut down is because they were being so successful with their community outreach programs and their outpatient programs. There was a lesson there for the whole mental health community, to the extent that they are successful in a genuine way in achieving community outreach and comprehensive outpatient care with the backup of inpatient facilities, then this Ministry of Health will penalize them financially and ultimately by shutting them down.

There is sufficient evidence on file with this committee to warrant us to conclude only one thing, that we are taking an enormous gamble if we permit the Ministry of Health to proceed with its unilateral, haphazard and unplanned and arbitrary decision to close those inpatient services. There is no other conclusion possible.

We have the evidence before us. If you want to play Russian roulette, you can count us out. We are not prepared to enter into that game. There is nothing, nothing, nothing in the record of this ministry with



respect to this issue that can justify the slightest iota of confidence in their capacity to retrieve a totally bungled situation. If they proceed with the inpatient transfer, it is inevitable that the bungling will continue and be compounded.

The staff at Queen Street cannot absorb this additional patient load, on top of the additional catchment area. We will have, in a very short period of time, what Dr. Duszta has been calling the total institution, the one big huge hospital serving a population of two million people. It will be overcrowded and the quality of the mental health care will deteriorate. They will be moving people through that hospital on an assembly-line basis. They will be discharging people who are not ready to be discharged, and there will be enormous difficulties within the communities as a result of that. It is all unnecessary, it is all totally unnecessary; it is all being done for the mean-spirited purpose of saving a few million bucks.

There are no other grounds for closing the place. It's not a fire safety hazard, we know that. That was a total fabrication. The place is safe. It is an excellent facility; it's not going to be any cheaper; it's not going to be any cheaper, we know that, too. We have evidence to that effect. It's going to cost just as much money; it's probably going to cost more money, as a matter of fact. There isn't the slightest shred of a reason to close Lakeshore Psychiatric Hospital, not one, except the financial imperative that this government has accepted.

Now, if you want to go along with that and accept the consequences, be clear what the consequences are. Those consequences are real and they will come back, I am absolutely convinced of that. There are going to be enormous problems as a result of this decision, if it's proceeded with. We have the opportunity to stop it, we do have the opportunity to stop it. If we can pass a majority report which states simply and unequivocally that the order be rescinded, that the hospital remain open, and that a thorough study be done quickly of what the full range of mental health needs are in this largest city in the province—before any further actions are taken—I am quite convinced that the Ministry of Health will have to respect that decision.

It will go to the House, it would be debated; if it passes here, it can pass there, and the minister will have a clear instruction from the Legislature of Ontario, with respect to this most important issue. If we throw it away now, the consequences will come back to haunt you, and I will dissoci-

ate myself now, as my colleagues are doing, from those consequences. We are warning you of them. We have the evidence to support our concerns.

Sean said yesterday, and he made this great impassioned Churchillian speech—it was a wonderful speech; I congratulated him afterwards; it was one of the most brilliant speeches he has ever made—he said unequivocally to the Minister of Health, I'll say it again, it was such a nice phrase, "I just want to tell you that I expect that we will revise your position substantially on both the inpatient and outpatients aspects." If it was good enough for May 15, surely, Mr. Chairman, it is good enough for May 16.

**Mr. Martel:** You haven't been around long enough.

[3:15]

**Mr. McClellan:** Fortunately I have.

Please, don't take this gamble. There is nothing to support the gamble, except the folly of a very incompetent Minister of Health, who has demonstrated his incompetence on a whole series of issues, and I know that the Liberal Party agrees with me on that. He has demonstrated his incompetence again on this issue. If you want to go along with that, you do that at your own peril.

**Mr. Belanger:** On a point of order, Mr. Chairman. What is the order?

**Mr. Chairman:** The motion is that the committee report and attach three separate statements to that report, and Mr. McClellan is arguing against that motion.

**Mr. Belanger:** Thank you.

**Mr. Lawlor:** Mr. Chairman, my position on it is that, of course, if a consensus cannot be reached, it is perfectly in order for each of the parties, I suppose, to send in their own reports. No one can prevent that, and that's part of the legitimate working of this assembly.

The only thing I have to say about it—and I tried to speed up the thing—is that the initial report submitted to the steering committee this morning, the Conservatives have altered in the meantime; they are accommodating and absorbing all the points that the Liberals had made this morning.

It appears to me like one document, and it's a hell of a lot easier to refer to one document rather than to two or three. In no way in the steering committee did we pre-empt the position that the New Democrats took. I am not going to spend a great deal of time on this, but no one can possibly take exception to the fifth point; that is a reaffirmation of what the ministry has said, namely, that



they'll keep the lands in public ownership. That's fine.

**Mr. Duksza:** He's already said that.

**Mr. Lawlor:** As to the second one, there is a huge "if." What the position appears to be is that if the other two parties are prepared to see the inpatients removed, and whether they do or not, I and I am sure all my colleagues are deeply concerned about these employees. If the inpatient facilities, of course, were retained at Lakeshore, then that obviates that whole difficulty. But on the tenor of the document that we were discussing at the time, that didn't appear to be the intention, at least in two quarters.

Therefore we must place reaffirmation upon looking after the employees. This again, is a ministry proposal, and it's up to each one of us to determine how serious all that is, and there are intentions in this particular regard. As these things have gone on, there are an awful lot of employees still out in the cold. Nor did we ever really get to the management employees outside the union contract—and there are many of them, too.

So, I don't think it's any real point of contention in the steering committee over those two issues. Where the contention arose was on the inpatient situation, and I want to make it abundantly clear. I adopt every word that Mr. McClellan has just said. I thought it was a succinct and penetrating argument, summing up in an objective way the evidence that we have heard over these wearying four weeks of hearings. It's impossible to come to any other conclusion than the conclusion Mr. McClellan just finished outlining.

The thing is abundantly clear. The announcement was done, I put it to you, arbitrarily. We are not cognizant of the consequences; we have good reason to be warned—and more than warned; threatened, if you will—as to what those consequences may very well be. My position is that the Liberals are saying, in effect, "Clear the place out, but in case we make a mistake, we want an opportunity to rectify it and, therefore, we want another report within two years." But Lord, everyone, that is after the event. After it's done, there will be no rectification. The water is over the dam and the thing is finished.

I'll put it to Sean that temporizing on issues of this kind doesn't help. It just muddies the waters and is not an integral and forthright approach to the issue and to the evidence that we have before us. The purpose of this meeting is to survey the positions and modify them, if at all possible, to come to some basic understanding.

I would think that, for instance, even in the Conservative document, an area might be embodied if they were at all amenable—I would like further definition of that fuzzy region in between inpatient and outpatient care. I would like an affirmation in this statement that certain units would have inpatients, and that the ministry affirms will continue to have inpatient care, and, at least as far as we can see into the indefinite future, will remain on the site. We all know what they are: retardation, retarded people with emotional problems, the AA unit at the hospital, child and adolescent care, and the influx of outpatients into the inpatient facility connected with those institutions. Nothing is mentioned of that whatsoever.

Of course, I would like to go one step further, even in the most modified statement. I believe that there should be a retention of at least a crisis centre with beds available for people who arrive in the dead of night, or at other times, either on their own or by way of the police. No accommodation is being made for that in modification of the statements we've seen before us.

I suspect, at the end of the day, that we will probably divide on the issue and that either one or more minority reports will go into it. The point is, I don't know how the hell you're ever going to get a majority report except that the Conservatives probably will see fit to join the Liberals in this particular matter.

**Mr. R. F. Johnston:** Speaking to the motion, I would oppose the idea of three separate reports. Like Mr. Conway in his speech yesterday, which I was very impressed with, as a new member I find sitting here and dealing with the issue as we're having to do today very disheartening. I thought what had happened over the last four weeks was that we had pulled together—some out of a hat, some because they volunteered, some because they were volunteered as ministry spokesmen—a whole series of witnesses. From very extensive testimony, I agreed with Mr. Conway yesterday, we picked up an impression that this thing had not been properly planned. The proper thought had not gone into this whole move, and I don't see anything today that should change that general impression.

I don't understand why it is that today, in essence, the Liberal members of this committee have decided to go along with the minister's position. They may argue that their points are substantially different, but I don't see how they can. By filing three reports all we are doing is allowing the minister to have his way. We've just spent

four weeks talking about nothing, for no reason.

A number of the people we've talked to over the last number of weeks have talked about this planning process and, in answers to myself and others, have said that planning should be done first. Then you close if necessary, but you don't close the inpatient facility as well as the outpatient, or both or either, and then try to handle the planning. Nothing has changed since yesterday that I know of, to say that we're getting anything different. To have, as part of the motion, the idea that we do a study after the fact, to my mind, is negating everything we've been up to.

I believe, as Mr. Conway did yesterday, that the minister made a bad decision and should be chastised for that bad decision because it had lack of input. He had the McKinsey report, he had the fire reports which have been shown to be totally useless and suspect, and those, besides discussions with his ministry officials, are what he made his decision upon. What he should have done was initiate planning, bring together community leaders and doctors and the kinds of people we've spoken to, and get their feelings and their ideas on this thing first. Then he could have made a decision that would have been reasonable.

I would suggest that all we've done in four weeks, because often our questioning has been curtailed by time, is skim the surface of this whole thing. We have not found all the answers.

I would just talk to a couple of things, if I can, in terms of the importance of having a psychiatric institution, not just as tertiary care but as a fulcrum, as a focal point for delivering outpatient services. I think we have had a number of people who spoke to that. The head of the volunteer association, Celia Royce, said she couldn't see that the volunteers would maintain themselves as they are now. Lakeshore had the highest inpatient-outpatient ratio in the province, and was already doing very well. Dr. Maharaj and a couple of others talked about the importance of inpatient backup to what they were doing. We have that down.

The inadequacy of relying on general hospitals was stated by any number of people, including Dr. Durost. He talked about when he first arrived in Toronto, he was on a binge of trying to convince people that you could get the psych units in general hospitals' attitudes changed substantially enough, and get adequate community resources to be able to provide more and more support in the community and make the need for the tertiary

institutions less. He called that "beating a dead horse." He'd given up on it.

We have Audrey McLaughlin who came to us from the Mental Health Association's Toronto office. "Two years ago," she said, "we did a study of psychiatric services in Metropolitan Toronto, and one just simply hears the same problems over and over again. Nothing changes and nothing has changed in two years in terms of outpatient services in the community to support people."

I think we've been given ample evidence that readmission rates were not just a matter of people being let out of hospitals too quickly, perhaps, because of the whole pressure in that direction, but also because there were inadequate services in the community to handle them. Those readmission rates, we know, are jumping incredibly already, without any extended catchment area.

We had Mr. Richardson who came in as almost a soothsayer. He was able to know before the ministry announced its intention that it was going to close the hospital and agreed with it beforehand, as well. I asked him, "Would it be as expensive to provide care in the community, or more expensive, than in hospital to do it adequately?" His response was "more". What we're getting is \$1.3 million. He indicated that the ministry's overall budget was \$156 million for institutional care and only something less than \$10 million, something like \$6 million, in out of institution care. How do you put those two things together and assume getting \$1.3 million extra is going to make any difference to the overall situation?

[3:30]

What we have been shown over four weeks here is that we have a crisis in mental health care in Ontario, that there is no infrastructure that's handling the problem. There are no housing standards that are handling the problem. We don't know, frankly, what these community services out there are doing in terms of helping readmission or not helping readmission. We don't know whether or not the percentage of the people we admitted to hospitals is greater from people who have received assistance out of these services, or not received assistance from these services.

There's no major study to show us how effective these things are. We're putting into effect, we're supposed to jump up and down with joy at this new range of \$1.3 million, or it could be more because we haven't got a dollar figure on it now, these proposals that come from Dr. Lynes' committee. We're supposed to be happy that they're going to handle the problem. I'd say that our evi-



dence over the last number of years is not just that inpatient numbers are less in hospitals these days, but readmissions are extraordinarily high, and that shows an inadequacy in community care, and here we are closing down an effective hospital to create what I consider will be a very large hospital.

We've heard talk about that hospital, that in fact it is not one hospital but four small hospitals, and is therefore not a major institution. Anybody who visited that hospital, number one, gets the impression that that's a very large institution. When you learn that there are already people being shifted from one unit to another, because of overcrowding in particular cases, and therefore going under the jurisdiction of another unit, you understand that it is not four little distinct units working on their own. It is a very complex institution.

In the wording of the motion, that first part really bothers me in its implication. It says, "In that we believe that the inpatients of Lakeshore Psychiatric Hospital should obtain the benefits of a more modern facility . . ." The evidence that Mr. McClellan gave to us just now, or repeated for us, for those of us who have obviously forgotten it, is that there are all sorts of indications that just going down to that modern facility is not going to add anything to patient care at all. In fact, it may be jeopardizing it.

Thank goodness for the union, because they're the only ones who broke it down, unit by unit. They're the only ones who gave us the information that the minister should have had in the first place and then maybe would have made a more rational decision. We've learned that right now they'll have at least 85 per cent occupancy. We know right now that that's considered to be full occupancy, and here we are talking about closing down the inpatient care in Lakeshore. I brought up the ridiculous situation where you have Whitby being built by McKinsey standards, based therefore on McKinsey projections on the one hand, and Lakeshore being cut out, supposedly for some rationale that is other than strictly financial, and it obviously is just not the case.

Mr. Conway, I think I saw you put your hand up. I want you to respond to this. I want to know what has made you feel that there's a substantial enough change to warrant letting this whole thing go ahead. Are you not concerned enough at this stage to say, "Put on the brakes. Let's extend this whole inquiry, for not just us, but get others into it. Let's hold it for a while. Let's not rush into this thing." We've got an institution at

Queen Street that we know is working well. Why jeopardize it? The majority of the evidence we've received is that we may jeopardize it. What's the point? Are we going to operate just for bucks too? Is that our rationale? I would hope not.

I would think that there are a number of other kinds of options that the ministry could have looked at that it didn't look at. I don't see why we don't move for smaller institutions in general. I don't see why we don't have tertiary institutions in the community. Why talk about having a Brockville 100-odd miles from Ottawa? Why not leave Lakeshore where it is as a small institution? Why not rebuild Whitby and Lakeshore in a piecemeal fashion over the next number of years?

I know Whitby intimately, and the ministry yesterday was going on about how great it was that he tore down those buildings. Those buildings had been vacant for years. I mean that was no big thing. He wasn't saving anybody anything. Whitby's major failure has been the fact that it's a part of a huge geographical area and has not responded to its outposts, and here they are going to build a new centralized big location, same size as it is now, on those same grounds. They aren't looking at the needs, as I see it.

I just think that we're getting caught up, and we're being fooled by the ministry, to think that this is one little issue of closing an outdated, outmoded hospital. Really what we've been shown is that our mental health care system in this province is in dire straits, and the way to open that up and to show that that's the case, and that should be our duty as opposition members I should say, is to demand a full inquiry into this thing and halt this thing before we endanger patients any further than we already have.

We have been told already by the medical advisory committee that there is a 34 per cent increase in admissions from the old catchment area, in the first four months of this year. Isn't that something we should take account of? McKinsey suggested that they only expand Queen Street by the 20 per cent catchment area. Why not look at that?

If Scarborough is such a great example, why don't we talk about bringing Scarborough into Queen Street, and leave Whitby with its problems out there, and go that direction instead? Why don't we look at other uses for those empty wards and maybe bring the Ministry of Community and Social Services into a more meaningful relationship with that hospital?

I would think that this thing is bigger than just the closing of a decrepit old hospital—and I think that it isn't a decrepit old hospi-



tal. We've seen that with our own eyes. I'm asking as a new member that members of the Liberal Party—I am asking Mr. Conway himself, if he would please respond and tell me what it is, why it is that he feels we should go ahead with the inpatient side of things now.

What is it in the evidence we have received that makes him feel so confident about it, when it was a recommendation of the minister, a minister whom he attacked so well, so eloquently, yesterday, for his whole approach to this thing? Why don't we look at this in bigger terms and demand the kind of inquiry this thing surely demands of itself?

**Mr. Kennedy:** Mr. Chairman, in responding to a couple of the points that were made; I really have a problem in seeing vacant beds in two locations which, if we followed the NDP suggestions, presumably would remain vacant. I just can't relate that to spending dollars when we have those facilities.

I was attracted to Mr. Conway's motion where this would be examined by November 30, because according to the plans now we have built in some flexibility, considerable flexibility, where we can perhaps have the best of both worlds through economy, good patient care and flexibility. An add-on which to me was very important was the statement by the minister on April 23 that the Lakeshore site would be retained for future use. It would not be disposed of. Here again, we add a dimension of flexibility that to me is very, very important.

So with respect to both the inpatient and outpatient services, I simply cannot see how, with the infusion of something like \$1.3 million for outpatient care as an add-on, that we're jeopardizing the health care. This hasn't come through to me at all.

Therefore, we have put this position forward and I merely wanted to reiterate that, and put that on the record because that's really getting down to the bottom line so far as I'm concerned, Mr. Chairman.

**Mr. Chairman:** So you're supporting the motion?

**Mr. Kennedy:** I will support the motion, yes.

**Mr. Duksza:** I spoke last time on a point of order that we should only have one report—that's why I'm speaking right now—because I spoke on a point of order and I thought that we would really have a majority/minority report. But the member for Lakeshore, Mr. Lawlor, has pointed out to me that there is really no reason why there shouldn't be more than one, though it seems that there should be three or four or five or six or seven reports.

**Mr. Lawlor:** I am going to vote against it though.

**Mr. Duksza:** Oh, I'm going to vote against it, of course. My reason for it is quite simple—it is a waste of paper to have two reports.

What I want to speak about now, since you gentlemen have allowed so kindly in effect to make this a major debate on the point at issue which we have discussed for the last four weeks and I will speak on that point—

**Mr. Chairman:** As long as you refer it to the motion before us.

**Mr. Duksza:** Constantly. Several things happened in the last 24 hours which made me revise certain opinions. I said to the ministry yesterday, and I will repeat it, and maybe it should be said even more harshly than it was said yesterday, the minister is an arbitrary minister. He does not seem to understand his ministry. He is in effect a nominee of some kind of management committee or budget committee, which only takes into account the needs of psychiatric patients at best secondly. It in effect only considers what budget constraints are imperative, and will dictate. He does not respect his mandate as a minister of the crown in charge of all health needs of Ontario.

I think basically he does not understand the health needs of Ontario. He is arbitrary; his ministry is chaotic. He obviously does not listen to his own experts. In some sense that bothers me most of all, that the minister does not even listen to his own experts.

He sets up a commission, called the McKinsey report—I'm not quite sure if commission is the right word—but he sets up a study, which pulls in a lot of resources; a study which tests and examines almost everyone in turn, and comes up with what seems like—within the limitations—a reasonable solution at the moment to the problems.

Then he immediately, quite blithely, arbitrarily and without real understanding, rejects it. He then in turn rejects almost every expert who came to talk, including, paradoxically, a number of experts he called from outside, who were supposed to come and support his position, which is to close Lakeshore on the grounds (1) that it was a fire hazard; (2) that this was a stupendous move for the community psychiatrists; (3) there was the imperative to fill beds in Queen Street.

I know, Mr. Kennedy, that nature abhors a vacuum. But must we go to the extent of filling a psychiatric bed with a patient, merely because the bed is there? That seems like a foolish way to approach it.

The minister doesn't listen to the experts. Mr. McClellan and Mr. R. F. Johnston have both repeatedly quoted the experts. I don't need to repeat the quotations of the people who have spoken. The people who came from the catchment area of Lakeshore—whether they were heads of departments; whether they represented social planning councils; whether they represented the staff of the hospital; whether they represented the volunteers; whether they represented the workers; whether they represented the community at large; whether they represented, in some sense, the people who suffer the brunt of mismanagement of the ministry, that is, the group homes, some of which are in my area, not supervised or standardized, where the patients are abandoned as backwards; out of sight, out of mind—all supported Lakeshore, in effect, as a fulcrum of many of the psychiatric services which has to go on.

Maybe people will say that is a biased opinion of what is involved, but these people work with the patients. They have had a relationship with Lakeshore. They perceive much more closely than anyone that it is disastrous to suddenly remove a focal point of the treatment by a very arbitrary decision.

There were also witnesses like Dr. Wasylenki, Dr. Munroe, Dr. Roberts, Dr. Durost and Mr. Richardson, who were called by the ministry. Some of their passages were paid because they had to travel long distances. They were called to support the point of view, in some sense, of what the minister has done. Under intensive questioning, almost every one of them had to admit to certain disquiet with the minister's decision.

[3:45]

The most classic was Dr. Durost, who is a medical administrator of Queen Street Mental Health Centre, and who talked literally non-stop from the moment he came in. If he was asked about the weather he would probably give a half-hour answer. He was very clever and very brilliant in giving long answers to everything, but then ultimately when you asked him, "Do you really? When did you change your mind about the McKinsey report?" he could not answer that because, in effect, being on a witness stand, in his heart of hearts, he knew that he didn't change his mind. He had to come here, as someone who works high up in the ministry and who could not very well say anything else. He agreed with me that to set up an alternative community psychiatric program in the community would take three to five years.

Dr. Wasylenki made a very impassioned plea that you cannot close the hospital unless

you have an alternative, because the patients will suffer.

Dr. Roberts, who was the most interesting witness of all, started speaking in a very Olympian fashion when he referred to that. After all, he has been so detached from psychiatry, being a chief and professor of psychiatry for so long, that he could talk. He has already solved all problems of psychiatry and has set up a community psychiatry program. He omitted, of course, to add that he himself is instrumental in sending anyone he doesn't think fits into community psychiatric problems to one of the 300 beds in Brockville which are kept as a reserve for the system that he so blithely calls community psychiatry, which, incidentally, I don't think he ever visits because it is so far away and so far out of sight. The patients are put into an ambulance and transferred. I know how it works.

But he made no case for closing, because Brockville is the same size as Lakeshore. The catchment area is even smaller, and if this brilliant community-oriented psychiatric program actually needs 300 beds, how can he come and dare to suggest to us that we don't need it, that we can just close it and everything will be taken care of, because the benevolent minister will give \$1.3 million to provide everything?

Dr. Durost and Dr. Wasylenki have stated that it costs as much to keep a patient in communities outside, but the point of doing it—and Dr. Anderson was more vocal about it—is that it is better for the patient, but it costs as much.

I wanted to cover more points. One of them is very personal. I know you cannot simply switch roles. You cannot simply stop being an MPP and talk from a different aspect, but of course I have two jobs, Mr. Chairman, in that sense. I have worked for over 20 years as a psychiatrist. I started working in psychiatry when the Queen Street Mental Health Centre was 1,200 or 1,400 people, when we used to admit 3,000 people into the hospital, when the average length of stay was months, if not years, when some of the wards were packed like sardines with human beings. The very fact that they were packed together like that in a locked area produced symptoms which had nothing to do with the original admission, but the conditions and the treatment were as inhuman as you could imagine.

We have forgotten that. We have forgotten because now we have a different system. The ministry has been responsible for certain changes, no question, under the guardianship of Dr. Dymond and a number



of other people, in some sense Bert Lawrence. The push has been towards humanizing psychiatry. It is when we stopped thinking of that that we ran into problems. I don't criticize Mr. Lawrence; I don't criticize Dr. Dymond. In some sense, even Dr. Potter had a feel of what to do. It has been only maybe since Mr. Miller and now Mr. Timbrell—and it's an interesting relationship because Mr. Timbrell obviously still takes his orders from Mr. Miller—that the changes have occurred. Now we are now concerned only with budgetary considerations, and not with the welfare of the patient.

I have worked on this, I know what it means when you have large hospitals, I know what it means when you don't take other patients. I have difficulty in expressing this to other members of the committee, that what we are doing right now is reversing the trend towards humanization of psychiatry. We should treat mental patients as human beings in providing the best we can offer the most unfortunate people in our society. I want to stress this and yet I don't want to become over-emotional in saying that I consider the decision of closing Lakeshore and depriving a whole community of needed services as one of the most disastrous for the people and patients for whom I have worked for years. I don't want to become full of pathos about this, but that is what we are doing.

Within five or 10 years, if we continue as the minister has done, abandoning discharged patients to their fate—often a most unfortunate fate in group homes or in the community at large without doing something for them, without providing them with financial support, after-care, occupational therapy or industrial therapy—we are playing with a significant but small percentage of people and by simply closing the hospital without thinking, by being preoccupied with the one large pretty institution at Queen Street, we are taking a significant risk now and in the future, because we are not dealing with major problems.

Second, the demographic pressure of our own area is such that we will crowd the Queen Street Mental Health Centre. They were built for single rooms. There is really no place. If it is going to be that crowded, we will have to have another institution at enormous cost.

The minister will come and say that of course the new progressive approach is to build a new hospital at enormous cost and everyone will have forgotten, including the members of the committee who are now supporting closure of Lakeshore, that this

decision will come to haunt us. If I can appeal from both sides, as an MPP and as a practising psychiatrist for 20 years, the decision is wrong from a human and technological point of view as to what is an appropriate thing to do in psychiatry.

Like some of my colleagues, I reacted very positively and strongly to what Mr. Conway said yesterday. It was in some sense a Churchillian approach, a Churchillian statement. I have seldom heard such eloquence. I was quite persuaded and I believed what he was saying. Maybe I should have detached myself from the brilliant rhetoric and looked at the content. Maybe there wasn't that much of a contradiction. It was a spendid "blood, sweat and tears" speech. In effect, the content did not match with what Mr. Conway wanted to say. I find that in some sense almost tragic considering the opportunity that the man had.

I believed what he was saying. In effect, he was seizing the leadership of this committee, setting a tone which would set the whole approach to psychiatry in a different direction. I believed it. But in effect, Mr. Conway, you sounded more like a banshee, a figure from Celtic mythology—you're of Irish descent—a person who wails and cries but in effect does not deliver. A banshee wails and cries at the death of someone, but is unable, or doesn't want to, or doesn't perceive that something needs to be done. I find that very tragic.

I started thinking, "Why such a waste?" All I can say about your speech, Mr. Conway, beside the fact that I am grossly disappointed about it personally, as a politician and as a psychiatrist, well—life may be but a walking shadow, a poor player who struts and frets his hour upon the stage, and then is heard no more. But it is a pity that your tale, let me quote Shakespeare at you, was told by an idiot, full of sound and fury, signifying nothing. I say this to you personally, that it actually hurts me to say it, because I really have seen you as a man who has potentially seized the leadership and could provide leadership.

Believe me, the four of us fought so long that the moment you decided to move towards that direction and respond to what everyone has been saying to you, you would have been the only one to have been seen as the person who led the charge. You have wasted an opportunity. And it is so obvious what you should do. It's a question of rescinding the order. Rescinding temporarily is a waste.

One of the things you talked about, was a task force to examine the psychiatric needs



of the Metro and neighbourhood areas. Within two to three years when they have done this, if it is an objective study on lines like but much more extended than the McKinsey report, something on the lines of the new Tighurst report, on the joint commission report in America, something on the new lines which will set us for the third revolution in psychiatry, the community one, then I would have accepted it when they made the decision to close the Lakeshore. No one is committed to the hospital per se. We are committed to good care but, Mr. Conway, at the moment it is disastrous for us to do it. Could I say I am so deeply disappointed. I am deeply hurt by his decision to reverse what he said yesterday and do something else today.

**Mr. Lawlor:** Mr. Chairman, I shall be very short and I shall presume to speak somewhat personally. After four hard weeks together, I want you to know that I am deeply disappointed as to what appears to be the upshot of this committee. I will go this far: I despair of either the rationality or the effectiveness of these committees.

If you had seen fit to delay the closing, then there may have been numerous consequences. We could have outlined, as my colleague has just said, a number of terms and propositions as to what we thought might come into being to give some direction to a study. I didn't want any prolonged study, anything sent in to the distant future. I thought it could be done rather rapidly. Originally, I had spoken of three months. Perhaps that's too short. Six months would probably be more in order. It would have set that whole community concept, given it an impetus, set it in motion, give it some definition.

For 10 to 15 years it has been talked about in this province and we know from what we have heard what has been done in this particular regard—virtually nothing, and this was our opportunity and our golden chance in order to bring some definition into the whole issue and as far as I am concerned, we are fluffing it. I will say a word to Sean personally. Sean, the tiger has proved that it has fangs but tigers have to have bite also, otherwise they lose their credibility. They know they speak one way and then act in another. That's remembered by members of the House and remembered by the government as to how they will hang in and to what extent they are prepared to back up the words that they speak. They tend to look down upon and diminish the status of a member who speaks too forcibly on occasion without when the time comes having

the bite to make that stick and be effective. That's a real danger.

**Mr. Chairman,** I am going to vote against the recommendation for this reason: I think that it should be defeated and that the Conservatives should go forward with the movement of their motion, and that we take a vote on that aspect. We shall no doubt then move the second motion with respect to our report so that we can get it before the Legislature. Why do I say that? Because the Conservative motion is identical to it.

There is no necessity for two reports, it's just bloody ridiculous as things presently stand. Conservatives, I think, quite in a political way have pre-empted the situation and so be it, that is an adroit political move, etc. We will proceed, if there is further debate; so be it, on a Conservative motion as it arises, and I would put it to you, Mr. Chairman, that that's the way this matter should be dealt with.

[4:00]

**Mr. Conway:** Mr. Chairman, initially I'd like to say, and happily, that my motion has served its purpose. It has focused attention in a direct and serious manner, a seriousness and a directness that from my personal point of view I felt wanting, one hour and 30 minutes ago. For that principal reason I would be quite prepared to table my motion for the time being, quite sensitive to the very timely contributions of the four members of the New Democratic caucus and my colleague from Mississauga. But, I do want to add a few things by way of what has been said earlier. I don't know where I send the OHIP billing to my friend in Parkdale, but I'm pleased to think that I owe at least that.

I want to reflect very momentarily upon the rather high and, I suppose, justifiably moral tone of their presentation today, about their perception, that somehow, I have changed my position within 24 hours.

Let me deal with the change of position argument and the lecturing that very properly has been engaged in. I remember five or six months ago being on a committee—I don't think with any other member here—that dealt with health-care policy, an interesting, productive committee, and at times, like this afternoon, a very personal committee. This was the committee that grew out of the OHIP business.

We disagreed on some fundamentals; I suppose we shouldn't have but we did, but there were some things on which we agreed. During the in-camera sessions, and I attended every one, I well remember a discussion on chronic-care user charges and the happy,

speedy and almost pleasant unanimity with which the eight members of that committee unanimously supported a recommendation that, on the face of the evidence heard over many weeks, was, in our view, eminently supported. It became part of the report, a report that I was basically proud of.

I'll never forget the despair, the inner turmoil that I faced when, within weeks of that unanimous and public report, one of the consenting partners, not sulking in a dark, murky corner far distant from Ontario, but there foursquare before the people on the provincial network, denounced as the work of apostates this treacherous and indefensible chronic-care user charge in all its aspects, without qualification.

Maybe that's a partisan interpretation of events, but I don't think it's altogether that partisan. I just mention it so that the context of changing positions might be more widely understood and appreciated, particularly by those who would, properly or otherwise, ascend the high chair of judgement from which to lecture those of us allegedly more imperfect in these and other matters.

**Mr. R. F. Johnston:** The stool was pretty high yesterday.

**Mr. Conway:** About positions; let me just say a few things. I don't know whether they are here but at least two journalists phoned me on or about January 22, the day on which the minister held his press conference, to ascertain the Liberal position with respect to Lakeshore. I remember my leader had given a comment here, in the city of Toronto, that I essentially supported, and it was a position which supported, on the face of the case put by the minister, that Lakeshore should be closed and that we would support it. That is the public position which my leader took and which I supported then. I want that understood. Neal Sandy from CFRB was one of the two reporters.

**Mr. McClellan:** We all know that.

**Mr. Conway:** Right. On January 22, or thereabouts, that was our response. Since honourable members opposite have, not unsurprisingly, argued the relative position of positions, I think it important to establish that for those who may not be aware of it.

Then what happened? I see one or two others in the room today whom it's been my good fortune to have met and dealt with over the recent number of months. I think particularly of an occasion when Sam Wood, one of the union representatives from Lakeshore, and John Firth, came into my office and discussed what could be done in this connection. I remember talking to the mem-

ber for Lakeshore, I remember subsequently an initial union brief or someone's brief—and I may stand corrected, but I think it was a union brief—which called for a full public inquiry into this matter.

I remember, and I stand corrected but only by the member for Lakeshore, having been out at a meeting in Port Credit in early March, I believe, when, together with our friend from Mississauga, Mr. Kennedy, we appeared before a public meeting. I well remember that rainy night walking down the steps with the member for Lakeshore who was inquiring about what we could do with respect to this matter and the public inquiry.

I think I am correct in saying that sometime there—or in my office just before, I suggested to either Sam Wood or to Mr. De Matteo, I'm not sure which, if either of them, that I was sceptical, and I'm particularly impressed by what the member for Scarborough West and the member for Lakeshore have said about the role of these kinds of things.

I remember thinking, on that day, that the public inquiry would meet much of the situation in which we, as politicians, found ourselves, that we could stand in the opposition, certainly, against the Lakeshore by suggesting that a public inquiry should be proceeded with. I took the position that it would be a disservice; it would allow us all to cop out with no real opportunity to discuss the issues which the local union representation had been particularly assiduous in putting before me and, I dare say, all other members of this House.

During the course of their education of me, at least, I was impressed by many of the unanswered questions. I remember particularly the point made by Sam Wood about the fire safety situation which was of great concern to me some weeks earlier.

At Port Credit, I remember suggesting to the member for Lakeshore that surely the way in which these very important and timely questions should be proceeded with was not the public inquiry that was being called for but, rather, by that oft-used mechanism of what used to be the old provisional standing order seven, special reference.

I remember his leaving that meeting in somewhat of a happy agreement in that connection because I think we both saw it, at that time, as a reasonably immediate and possible mechanism available, not to some commissioner, not to some independent third party, but to those of us whose mandate is such affairs as the closure of Lakeshore. I was



both unsurprised and very pleased a few weeks later to see the member for Lakeshore on his feet during or after question period, taking that initiative. I was unhappy that the Speaker, if I'm correct, refused the first but allowed the second and created this committee.

Those are just some of the background bits. I'd like to think that some of us had something to do with the creation of this particular exercise. I do think it has been positive and useful. I remember feeling a little bit, oh, sheepish, I suppose, out at Port Credit because I didn't stand up and say that I had changed my position, that I believe that Lakeshore should be kept open. I would, in a sense, have liked to have done that, because that was the mood of that and, I suspect, many other meetings. But what I do remember saying was that I was anxious that these matters be reviewed, that the serious questions be put, the evidence heard and a judgement made as quickly as possible. I said no more than that.

So I, like other members, came before this committee with a position; and that position was the one articulated by me and the Leader of the Opposition (Mr. S. Smith) on or about January 22, 1979. Let us not forget that I think I indicated to a number of the Lakeshore people that I had to be persuaded that the initial initiative was a wrong one. It is in that connection that I have listened for four weeks to the evidence in a reasonably impartial manner, I'd like to think.

I came in feeling that on the inpatient question the ministry was right, in the first phase or in the immediate period and the immediate future. The more witnesses I heard, the more concern developed within me privately, that we were potentially opening the door to a truly ruinous situation in the not-too-distant future. I still feel that way, that the potential is there for serious difficulty. I think the evidence supports that.

But, as to the cumulative effect of the evidence of the witnesses that I heard in my own way, I regret, with Sam Wood and others sitting not too far from me right now, that I can't report to them that the evidence has been of such a kind as to make me change my initial position with respect to the capacity of other institutions, Queen Street in particular, to accept and effectively deal with the inpatient load which presently finds itself at Lakeshore. That's the way in which I came into this committee, and that, unhappily as it may be for members opposite is the way truly, sincerely and honestly I feel today.

We can transfer the bulk of the inpatient load at Lakeshore to Queen Street in particular, in the not too distant future. In my view not only will those people be cared for but they will be cared for in a facility which is an improvement over that in which they presently find themselves. That is to say, nothing more than the bricks and mortar of a facility which was built in the not too distant past is more likely than not able to provide a better institutional framework than a structure that was 90 years old. Whether or not other offsetting circumstances like the particular quality of Lakeshore would be a sufficient countervailing force, I have not been convinced. I regret to tell you that.

That is a position which I believe, on the basis of the evidence which I have heard, is supportable. Clearly some hon. members are going to disagree with me on that. That does not surprise me.

**Mr. R. F. Johnston:** Why were you upset yesterday?

[4:15]

**Mr. Conway:** In so far as the evidence about outpatient facilities is concerned, I have been convinced that most of what I was told by people associated with Lakeshore would indeed come to pass if the minister's initial position—I want to make this clear—today and yesterday I talked about the minister's position of January 22, where they started and where they wanted to go on this matter at that time, notwithstanding the countless concessions which the minister seemed to be making, all of them imminently justifiable to the member for Lakeshore in his last round of questioning yesterday.

I believe very strongly that the ministry did not in any way take into consideration the planning requirements and I daresay the planning imperatives with respect to the maintenance of quality outpatient services at Lakeshore. To the best of my ability I tried to reflect that conclusion in our series of recommendations.

As well, I am sensitive to a point to which I made some reference not very long ago about the situation, certainly three, four and five years from now. I want to repeat, about the capacity of Queen Street to accept the bulk of that transfer and to provide quality institutional care, I have no qualms. I do have substantial qualms about the intermediate impact, or the impact of that over the decade of the 1980s, particularly in light of the facts and figures which a great number of witnesses has brought before us.

It is for that reason, Mr. Chairman, that I want an exhaustive study, a study independent of both the ministry and government



on the one hand and McKinsey on the other, which will assess the inpatient and outpatient needs for the greater Toronto area, and that this be done and made public within a two-year period, and therefore provide the basis for future health-care planning in this particular part of the province and in this particular category.

Notwithstanding the considerable rhetoric of particularly my friend from Parkdale, I don't sense that there is a great gulf on that question and in that connection. Much has been said about the three points that we put and how they may or may not reflect—

**Mr. Duksza:** For the record there is a major difference.

**Mr. Conway:** Mr. Chairman, I awaited with much interest and considerable anxiety the report of my colleagues from the New Democratic Party. What does it tell me in four and one half pages? Well, it's interesting. The principal recommendation is that, not surprisingly, the order be rescinded, and nothing be done until a study of their recommendation be entered into and completed.

**Mr. Lawlor:** A full system study.

**Mr. Conway:** That's right, but I want to talk about that, Mr. Chairman. And just listen to some of this. "We believe," says page four of the NDP paper, "that it is imperative that a full system study of the mental health needs of the Greater Metropolitan Toronto area must be begun, completed and evaluated before any decision is made to terminate."

I want to come back to the condition that was established by Mr. Lawlor earlier today. The mental health needs of the Greater Metropolitan Toronto area must be begun, completed, and evaluated before any decision is made to terminate. I want to come back to the caveat, the condition that was established by Mr. Lawlor earlier today.

**Mr. Lawlor:** Written into.

**Mr. Conway:** Yes, all right. That such an independent study would require extensive community involvement, and not simply a hasty review by a few of the proposals for outpatient services, most of which were presented to the ministry long before any inking of the intention to close Lakeshore. The key phrase is that extensive community involvement—and three cheers for that, I couldn't agree more—within wider terms of reference—

**Mr. McClellan:** As the Williston report. It's about the same time frame as the Williston report.

**Mr. Conway:**—within wider terms of reference, this thorough analysis of mental

health needs, would be able to confirm or deny the central conclusion of McKinsey.

**Mr. McClellan:** As the Seebom report. It's about the same time frame as the Seebom report.

**Mr. Conway:** We insist that the full range of community programs and a co-ordinating medium be well established and functioning, all of that eminent good sense, and some more that I could add.

**Mr. Duksza:** We've as yet to vote with that motion.

**Mr. Conway:** And then the rider that this be done in six months. It may be that the member for Bellwoods can cite chapter and verse of precedents. But I remember some months ago being told that residential tenancy legislation could be dealt with in a certain focused period of time—

**Mr. R. F. Johnston:** Six months before—

**Mr. Conway:**—and I question, Mr. Chairman, if given this mandate there is any hope for that report before the millennium.

**Mr. Duksza:** Do you believe in surgery first and diagnosis afterwards?

**Mr. R. F. Johnston:** Exactly what you attacked the minister for.

**Mr. Conway:** Mr. Chairman, I find it somewhat strange that such an extensive and wide-ranging study be completed within six months. I have no faith in its capacity—

**Mr. R. F. Johnston:** Extend it to 10 months. Prolong it.

**Mr. Conway:**—and I want to draw that to the members' attention.

I wonder, and perhaps I am being political here, how far the members are prepared to go in this connection. Before I explain that last point—and that will be my second to last general point—I want to say again, as having been part of the select committee on health care, that you know when it was all said and done we started our inquiry looking at OHIP, the premium mechanism. We were forced to conclude, while we couldn't agree on some other things, that there was a shocking situation in the premium assistance mechanism. It was an absolute unhappy and known failure and we recommended that something be done as quickly as possible.

We were pretty indignant at the time that something be done. I suppose as one member of that committee I wish that that April 10 budget had had in it a package of reform that we directed, that was agreed to, generally speaking—by "we" I mean the committee—but it wasn't there. It wasn't there. How inconsistent are those of us in that connec-

tion for not doing something about it. I guess one of the concerns I would express in an unguarded moment is that we have but one final weapon in our arsenal as opposition politicians, and that is to force the government to do what we believe the public interest demands, and if they do not, a plague on their house and an election for the people, and that's fair enough.

**Mr. R. F. Johnston:** We can have a non-spineless, non-believing recommendation, I would say, Mr. Conway.

**Mr. Conway:** Mr. Chairman, I do believe I have the floor.

**Mr. Chairman:** Yes, you do.

**Mr. Conway:** I keep that in mind when it is suggested that the government should be driven to the wall, excepting, for example, the totality, to use a Clarkian phrase, about the NDP position. I wonder just how far they are prepared to engage their members from Algoma and Cornwall and Nipigon and elsewhere, on this very important issue. There may be a determination to take us all a great distance. This committee has a second term of reference, and I certainly hope that all members who participated in this are here for that, because I've got to tell you I know it's coming. I know that a lot of other members know it's coming as well. We're going to have a whole host of public general hospitals before us, of one kind or another, complaining bitterly of a strangulation process that threatens their very existence.

As far as I'm concerned, this committee has heard the evidence, and my colleagues have been impressed by the evidence. If you heard me say yesterday that I was four-square for the maintenance of all inpatient services at Lakeshore, if you heard me say that yesterday, if somebody heard me say that in my office, if somebody heard me say that at Lakeshore, then—

**Mr. McClellan:** All we've heard was what you said.

**Mr. Conway:** —then I expect more by way of rebuttal than what the member for Bellwoods has repeated to me this afternoon. What he has repeated to me is, of course, what I said. As far as I'm concerned, the position which we have adopted, a position which we took to the steering committee, which we take to this committee, was a position for negotiation. I think the member for Lakeshore—and by that I mean the statement that I took to the steering committee, was a position which was not so inflexible as to be impossible to deal with. I think we had a fairly good discussion.

**Mr. Duksza:** I think it was pure rhetoric what you were saying yesterday.

**Mr. McClellan:** There was nothing pure about it.

**Mr. Conway:** I said yesterday that I deplore the way in which the minister had put forward—

**Mr. Duksza:** You had me fooled. I thought you meant it, but then of course one shouldn't take things for granted.

**Mr. Chairman:** Order. Mr. Conway?

**Mr. Conway:** I said yesterday, for example, that I deplored the way in which the minister expanded the arson argument out of all context. I recall being somewhat indignant yesterday in that connection. If that is somewhat translatable, I recall yesterday saying that the planning mechanism, and in particular with respect to the outpatient services, was the kind of planning I could never, ever live with, and would never want to see again.

But on the principal aspect with which the honourable members from the New Democratic Party take exception, and that is inpatient, I believe I said nothing at all about a final conclusion on my part with respect to how I was going to come down in that connection. Because I believe, rightly or wrongly, that today or any time after which we've heard all the witnesses, is the time for a statement in that connection.

You disagree with me. You will cite your evidence and I will cite mine, and I think that's a healthy difference of opinion.

**Mr. R. F. Johnston:** We heard all the evidence yesterday.

**Mr. Conway:** From my point of view, what I said yesterday is consistent with my position throughout these hearings. I want to conclude, Mr. Chairman, by stating that I resent what I know to be an accidental construction based on my remarks by not only members from the New Democratic Party on this committee, but also, I understand, from my colleague from Sudbury East, by others who've gone about this room fulminating that I've somehow changed my position.

[4:30]

On my position with respect to inpatient services, I want to say this: On January 22 I pointed out where we stood. Today we introduced a document which I think is consistent with that position. I regret in a way that we were not perhaps dissuaded from it, but I believe the reasonable man or woman hearing the evidence we heard in that connection would be—



**Mr. R. F. Johnston:** To move Lakeshore, any part of it?

**Mr. Conway:**—the reasonable person hearing the evidence put before us would not be unsympathetic with a position which says that for the bulk of the people currently housed on an inpatient basis at Lakeshore, their immediate needs would be well met in the unused capacity at such facilities as Queen Street and that, as a future planning process, the ministry engage a full study of the needs which may, or may not lead them and others to conclude that indeed, as the member for Lakeshore and others have suggested, a new but smaller, or somehow changed, Lakeshore is indeed called for.

I feel that I have had to take this time, Mr. Chairman, because I was a little resentful of the imputation, almost, of my motives, or the way in which I have dealt with this committee. I resent, and I want the honourable members opposite to know that I resent, very much their position on the changing of attitudes. Members of my caucus took the position that we would hear the evidence, hear it all, hear it out, and make a judgement. That you do not approve of what we have, in part at least, decided upon, does not surprise or concern me, but I am unhappy as one member, at the fact that others, some of whom I know very well, would in particular, having recent experience in mind, decide to lecture me and any of the press and other who would listen that I have somehow in a calculated fashion changed my position.

**Mr. Chairman:** Mr. Conway, I gather that you are prepared or that you wish to withdraw your motion for the time being. Is that the import of what you indicated?

**Mr. Conway:** Yes, I am.

**Mr. Chairman:** At the same time, Mr. Lawlor has said he feels the committee should proceed on the basis of dealing with the redraft and voting on it and then dealing with the material which was submitted by the NDP caucus. Is that your indication?

**Mr. Conway:** I am wondering, on a point of order, would the committee entertain a five- or 10-minute recess? I have an urgent call I have to make and I don't want to miss it.

**Mr. Chairman:** I presume we can deal with the matters rather quickly that are before us now, if we proceed on that basis. We have the so-called Conservative redraft; I guess we have entitled it that.

**Mr. Kennedy:** Mr. Conway's motion is being withdrawn—the one we have been speaking to all afternoon?

**Mr. Chairman:** And tabled for the time being, yes.

**Mr. Conway:** Well, are we going to approach this redraft, as it's called, from the point of view of seeing whether or not there is some, or any, common ground?

**Some hon. members:** No.

**Mr. Duksza:** No, no point in that. We'll just vote on it.

**Mr. Conway:** Mr. Chairman, then, I want to be clear. If there is no commitment from the members of the New Democratic Party to consider those parts of that redraft, specifically points four and five, which were agreed to in the steering committee, and if there is no desire whatsoever at least to express that much or any other middle or common ground, then I don't want to be associated, in all due respect, with a position other than that which I submitted on behalf of my caucus colleagues to the steering committee this morning.

**Mr. R. F. Johnston:** Nothing else you have said has.

**Mr. Chairman:** Under those conditions, Mr. Conway, are you suggesting then that your motion should stand and we vote on it?

**Mr. Conway:** Yes. Because I thought there was some understanding we would at least agree on the points of—

**Mr. McClellan:** I assume what will happen is that we will each move our reports—

**Mr. Duksza:** The motion is passed now.

**Mr. Chairman:** If Mr. Conway's motion is passed, each party will then move the reports of the party and they will become part of the report which I will submit to the House.

**Mr. Conway:** I don't agree, Mr. Chairman.

**Mr. Chairman:** Are you ready for the question?

**Mr. Lawlor:** Ready.,

**Mr. McClellan:** Sorry, hold on. No, I don't know what the question is at this point.

**Mr. Chairman:** Well, it has been a long time.

Do you wish me to read the motion?

**Mr. McClellan:** I'd like to know what it is before we vote.

**Mr. Chairman:** Mr. Conway moved that each party submit its recommendations re the Lakeshore hospital matter to the chairman of the social development committee, and that these three statements stand as the report of this committee to the House.

**Mr. Conway:** And in my motion I intend our statement to be our position enunciated by the New Democratic Party at the steering committee this morning. I am taking the



initial Conservative position, in that I don't recognize any redrafts for the purposes of my motion.

**Mr. Kennedy:** Mr. Chairman, that is acceptable if an amendment is acceptable to the Liberal Party or to the committee, and that is you amend that by adding items 4 and 5, and I'll call it the Conservative redraft.

**Mr. Chairman:** That will be up to you, Mr. Kennedy, to submit it on behalf of your caucus, if Mr. Conway's motion is passed.

**Mr. Kennedy:** Yes, but the trouble is, his motion says that that be the report of this committee.

**Mr. Conway:** No.

**Mr. Kennedy:** Yes it does.

**Mr. Conway:** Mr. Chairman, I'll define my motion. I just want to be clear on this. It is the intention of the mover to accept the statements that were introduced by the individual caucus representatives to the steering committee.

**Mr. Lawlor,** a five-minute recess would certainly satisfy me.

**Mr. Chairman:** Agreed.

The committee recessed at 4:40 p.m. and resumed at 4:50 p.m.

On resumption:

**Mr. Chairman:** I call the committee to order again. You've heard the motion before the committee. Are you ready for the question?

**Mr. McClellan:** I'd like to hear it again.

**Mr. Chairman:** All right. I'll read the motion again. Mr. Conway moves that each party submit its recommendations re the Lakeshore hospital matter to the chairman of the social development committee, and that these three statements stand as the report of this committee to the House.

**Mr. McClellan:** For purpose of clarification, I have given a copy of the NDP report with two additions—one that Patrick had already referred to on page four which adds the phrase "completed and made public within six months" to the fifth paragraph—

**Mr. Conway:** Is there a second one?

**Mr. McClellan:** Yes—and a second addition which goes after the concluding paragraph on the fifth page which reads, "Since we are opposed to the closing there is no necessity to make proposals for alternative employment. The full staff should be retained. Further, we of course take it for granted that the Lakeshore Psychiatric Hospital grounds remain in public ownership." I have given a copy of the revised report to the chairman.

**Mr. Chairman:** Are you ready for the question then? All those on favour of the motion, please signify.

**Mr. Conway:** If you're going to accept that, and I presume that we can, I did not because I was going to entertain one or two small verbal amendments in mine, if that's acceptable, Mr. Chairman.

**Mr. Chairman:** Yes, it is acceptable.

**Mr. Conway:** Then I would just—

**Mr. Leluk:** Why don't you just accept our position paper?

**Mr. Conway:** No, I'll give this to the chairman, that our point number two will read, "In that there is a clearly demonstrated need to maintain and improve the outpatient services presently connected to Lakeshore, we recommend that these community services be enriched and expanded and that no bureaucratic difficulties associated with the transfer of inpatients be permitted to interfere with the achievement of this goal"; and then point number three, a concluding sentence added to read, "In this regard we recommend that the site be retained in public ownership."

**Mr. Chairman:** Are you ready for the question now?

**Mr. Duksza:** Mr. Conway's motion?

**Mr. Chairman:** Yes, this is Mr. Conway's motion. All those in favour, please signify. All those opposed? The motion is carried.

I can just say that I regret we couldn't come to some consensus. I think it would have been preferable, obviously.

**Mr. Duksza:** Mr. Chairman, don't you think we should try the Conservatives, as they're willing to change for various political reasons, to accommodate the motion? I wonder if we should not make an attempt, because if it's only a comma, surely Mr. Conway would accept the difference of a comma or a period.

**Mr. Conway:** What I am interested in, Mr. Chairman, is the suggestion of the member for Lakeshore who communicated to me earlier there would be an effort made to debate this matter in the House at an early and appropriate opportunity. I don't know how we pursue that, but—

**Mr. Lawlor:** Let me intervene on that, Sean. I want to refer to section 30(c) of the standing orders for the House. It says, "When presenting a report, the chairman of the standing or select committee may move the adoption of the report if it contains a subsistent motion." I suppose these contain a number of subsistent motions. "After moving the adoption of the report, the chairman may make a brief statement and then adjourn the debate. The adjourned debate should be car-

ried on in the Order Paper daily, to be called by the government House leader in the same manner as government orders." I would ask that it be done in that way.

**Mr. Chairman:** That's correct. Thank you, Mr. Lawlor. I don't know of any remaining business.

**Mr. Conway:** The steering committee I trust will meet soon to discuss the second term of reference dealing with active treatment beds.

**Mr. Chairman:** Presumably we will be meeting next Wednesday. The House doesn't meet either Monday or Tuesday, but we will, if the steering committee can arrange it.

**Mr. Duksza:** Not Monday, not Tuesday, but Wednesday.

**Mr. Chairman:** Wednesday, to deal with the hospital bed cutbacks; a week today.

**Mr. Kennedy:** The steering committee can meet today after regular proceedings with the House, Mr. Chairman.

**Mr. Chairman:** I think the scheduling is going to be up to the steering committee and if the steering committee wishes to have the minister, that should be transmitted to him as quickly as possible because obviously he has to arrange his schedule as well.

**Mr. Lawlor:** Mr. Chairman, just one other small point. I shall no longer be on the steering committee. Mr. Mike Breaugh will be available the day after the election and I hope would resume his responsibilities.

**Mr. Chairman:** Thank you, Mr. Lawlor.

**Mr. Kennedy:** Mr. Chairman, the steering committee had agreed that the minister would be asked to come on the 23rd to start off with a statement with respect to the second part of the resolution.

**Mr. Chairman:** If that has been agreed upon, then I suggest the minister come initially and we'll hear the delegations from hospitals thereafter.

The committee adjourned at 4:56 p.m.

## SPEAKERS IN THIS ISSUE

---

Belanger, J. A. (Prescott and Russell PC)  
Conway, S. (Renfrew North L)  
Duksza, J. (Parkdale NDP)  
Grande, A. (Oakwood NDP)  
Johnston, R. F. (Scarborough West NDP)  
Kennedy, R. D. (Mississauga South PC)  
Lawlor, P. D. (Lakeshore NDP)  
Leluk, N. G. (York West PC)  
Martel, E. W. (Sudbury East NDP)  
McClellan, R. (Bellwoods NDP)  
Van Horne, R. (London North L)









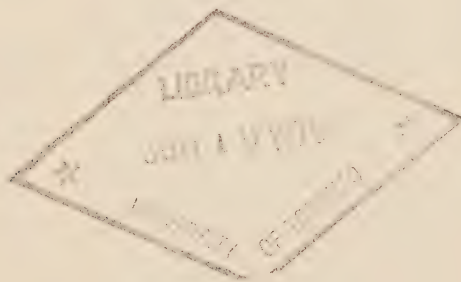
No. S-17

# Legislature of Ontario Debates

## Official Report (Hansard)

**Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Wednesday, May 23, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.

Editor of Debates: Peter Brannan.



# LEGISLATURE OF ONTARIO

---

WEDNESDAY, MAY 23, 1979

The committee met at 2:20 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Chairman:** I will call the meeting to order. I want to tell you, dear friends, that we're gathered here today—I guess that's another ceremony for another time, isn't it? In any event, what happened after our last meeting last Wednesday deserves a little bit of explanation. I want to give that explanation to the committee.

Last week we arrived at a committee decision in which the committee decided to report back to the House, and to do so in a manner in which each individual party submitted what amounted to three party statements with respect to the individual party's position concerning the closing of Lakeshore Psychiatric Hospital. Subsequent to that, Mr. Lewis, the Clerk, indicated to me that that form of reporting was in violation of standing order 89(d) which I shall read to you. It says:

"The report from a standing or select committee is the report as determined by the committee as a whole, or a majority thereof, and no minority report may be presented to or received by the House. A committee may, in its discretion, include any dissenting opinions in its report."

In my view, I read that to say, or at least the first part of that, to say that a committee may, in its own determination, submit any kind of report it wishes. That was my interpretation.

I indicated to Mr. Lewis, and I also indicated that, with respect to the Hydro committee, there had been a circumstance, I believe, with respect to the uranium matter, where the three parties had submitted three separate statements and that, indeed, had formed the basis of the committee's report. He indicated that that being the case it was done in error and that section 89(d)—

**Mr. Breaugh:** Passed in error and put into law in error.

**Mr. Chairman:**—still stood and that, of course, we as a committee had to abide by that standing order.

I read it again and see no difficulty in the first part at all. That's the reason we're here today. I indicated to various members last week that there was a problem, and that I wouldn't be filing the report last Thursday in the Legislature, and that we would have to call the committee together again today, and try and come to some kind of consensus with respect to this report.

Having said that, I think that that section 89(d) should be referred—and I would hope that perhaps this committee would refer it—to the procedural affairs committee so that we can have a definitive answer on that matter, a definitive answer, definitive interpretation. Mr. Breaugh.

**Mr. Breaugh:** Mr. Chairman, I don't want to interfere with the deliberations of the committee but I would like to put on the record that, in my view, the Clerk of the House does not make the rulings of this House. I certainly don't understand on what basis a Clerk of the House could refuse to receive a committee report of any kind. It is not his job to make a ruling in the House. The Speaker does that. At least, at the very least, the committee, in my view, should have been allowed to table its report with the House.

Subsequent to presenting that report, whatever it might be, if the Speaker of the House decided that your report was not in order, or if a member of the House decided that they wanted to challenge that under that standing order, then you could get a ruling and it could be referred to anybody you'd care to refer it to. But I fail to see, frankly, how the Speaker can interfere with the process between the committee and the House, or the Clerk can interfere with that process between the committee itself and the House.

You've quoted precedents that are there. In my view, understanding what the committee did last week, the committee arrived at its report, the shape and form of which is left up to the committee. The standing order 89(d) speaks to not having minority reports, but rather having dissenting opinions, if you want. I don't see even the grounds for the Clerk objecting because technically, in my view anyway, that committee report

goes from this committee to the House. There is no one in between.

Of course, the Clerk can always advise the committee which, I suppose, is technically what he is doing here. But I surely object, in principle, to the notion that a committee report is subject to vetting by any other person or party, and certainly, by someone who is not a member of the House. Just on principle, I would caution the members of this committee not to establish that precedent.

**Mr. Chairman:** I certainly understand and appreciate your point, Mr. Breaugh. When I read that section, the report from a standing or select committee is the report as determined by the committee as a whole. The committee as a whole, last week, determined that we'd have three separate reports. I'm putting that before the committee, and indicating to you exactly what happened, and why we're back here today. I thought it only fair that I should tell you what happened because I think all members were expecting that a report would be filed on Thursday last, and it wasn't. This is the reason why it wasn't.

So that brings us to the point of where do we go from here? I think there are essentially two matters in question at the moment. There is the matter of interpretation of that section 89(d), and what we should do about it. Perhaps it could be referred to the procedural affairs committee. That would be an adequate way in which to deal with it at this point. Then the procedural affairs committee can report back as to their findings. Perhaps, in that way, the section could be clarified.

Whatever the committee wants to put in its report, that's up to your committee, Mr. Breaugh, but I would say that would be the course I would certainly advise at this point. I think it would get it out of the way.

**Mr. Kennedy:** Send it to procedural affairs, Mr. Chairman.

**Mr. Chairman:** Yes.

**Mr. Conway:** On that point of order, if I might I will very briefly say that we in the Liberal caucus do not accept in any way the Clerk's interpretation of that particular standing order. While we do not feel bound to carry out the injunction that we must abide by the implication of that interpretation, we are prepared today to, nonetheless, work towards some kind of report.

For the record, Mr. Chairman, I wanted to indicate that, both for the reasons given by the member for Oshawa, and I think, the clear pattern of experience here, cer-

tainly in my four years—and I can think of the select committee on health-care costs and financing which, in its critical area, agreed to disagree and submit three rather different points of view—we could not accept that interpretation of 89(d). Speaking as one member of my caucus, I would be quite happy to see that referred to procedural affairs for some clarification.

**Mr. Kennedy:** I tend to agree. I've never had this experience—to have a rejection by the Clerk of a committee report. I can see it going in, he takes a look at it and then notifies us it's an improper report. It may be an improper report in his view, I don't know. Nevertheless, it's what we spent many hours—I don't know how many—

**Mr. Chairman:** Several.

**Mr. Kennedy:** —a day or two, several, in preparing and this is the resolution we had to the problem. I would go along if you want to send it to procedural affairs, but I think we should re-file it with him and if he declares it's improper, it could also go that route, if they like, to procedural affairs.

**Mr. Pope:** File it in the House.

**Mr. Kennedy:** I just offer that I'd like to make it a point.

**Mr. Chairman:** That's a suggestion. Could I have a motion then to refer this matter to procedural affairs?

**Mr. McClellan:** The implication of what Mr. Kennedy was saying is that you go ahead and file the report. I would certainly support that. The wording of the motion that Sean put before us, and which we approved, was that each party submit its recommendations re Lakeshore hospital and that these three statements stand as a report of this committee to the House.

[2:30]

**Mr. Conway:** That's right.

**Mr. McClellan:** So we have a report. My inclination is to accept Doug's suggestion that you go ahead and file the report. My assumption is that it will be accepted by the Speaker.

**Mr. Kennedy:** I don't see how he can refuse it. It is the House that refuses.

**Mr. McClellan:** If it isn't accepted by the Speaker it seems to me that is the point where the matter should be directed to procedural affairs. But I don't anticipate that happening, quite frankly, just on the basis of precedents around here.

**Mr. Lawlor:** I do think that the Clerk was unduly legalistic and probably took too much upon himself in this. Surely it is within the



jurisdiction prerogatives of the House itself. True, we would have to have unanimous consent. Whatever has unanimous consent is the rule, overriding any other document that was written. As I see it it would simply be a matter of using the words "dissenting opinion," a minority report. There is certainly no harm in it; the central thing is that we disagreed.

I am inclined to suggest that we keep that as an open option for the discussions today, and don't vote on it at the present time. If the thing comes to a state of abortion, then we resume our positions. What I am afraid of—and we are all afraid of, I am sure—is that the Speaker will listen to the Clerk, and rule it out of order, then we will all be back here in a kind of session that we were supposed to have today. How are we going to work that in with the Health estimates coming on?

We are all anxious, I am sure, to bring this to a termination one way or another.

**Mr. Chairman:** Is it the general consensus that I file the report tomorrow in the House, including in that report the three separate statements of the parties? And that if it is ruled out of order by the Speaker, it simply be referred to the procedural affairs committee for a ruling?

**Mr. Rowe:** I would be inclined to agree more with Mr. Lawlor's summation of the situation. If it is an improper report why file it, if in fact we can, by a bit of discussion today, file a proper report?

**Mr. Chairman:** I am in the hands of the committee. I just want to make some progress somewhere.

**Mr. Rowe:** If we can't at the end of the day, then the motion might be in order.

**Mr. Chairman:** You are suggesting, as Mr. Lawlor has done, that we attempt to get some kind of consensus? In that event, presuming that the committee could come to some consensus, there wouldn't be any problem. It would certainly comply with standing order 89(d).

**Mr. Conway:** In that connection I would agree, for two reasons. One, my colleagues met when we did receive the word, on Thursday I believe, that an effort would have to be made. We did not, unfortunately perhaps, think about all the orders as we should have, but we did meet to discuss that particular injunction.

When we met this afternoon in the steering committee, I indicated that our statement would be amplified in one area that the other two members of the steering committee are aware of. The reasons for that are

basically twofold. In the discussions here on Wednesday last—in fact in my own statement—there were two or three amendments or amplifications that were just written in. I think the Clerk would confirm that. I did not include a written part that was thought useful by some of our members. We basically stand by our three-point program.

In the light of the Clerk's suggestion of last week, and the discussions we held over the course of the intervening days, we had decided—and I indicated this to the steering committee this morning, mindful that we might be forced into some kind of accommodation for purposes of standing orders—to simply amplify our point one, by adding certain words.

It was discussed in the steering committee. I just want to indicate that what Mr. Lawlor has said and what Mr. Rowe has agreed to is something that I and my colleagues are interested in discussing, if only to see whether we can avoid the technical and legalistic problems of an improper report. It may be that we can't, in which case we can live with our unanimous interpretation of the rule for the here and now. Very briefly, we can readily accept Mr. Lawlor's and Mr. Rowe's points.

**Mr. Chairman:** Mr. Conway, before I have you indicate the change you are proposing to the committee, I will call on Mrs. Campbell.

**Mrs. Campbell:** I was just suggesting that we should follow Mr. Lawlor's suggestion and not come to a conclusion until we could see whether or not there could be some consensus. No matter how we feel about what the Clerk has done, it seems to me that in the best interests of getting the thing forward, if we could arrive at a consensus, it would be far better than trying to stick to the three positions and then perhaps fall in the House.

I don't appreciate what the Clerk did and I don't think it was his position to take that position with a report. There is not much point in fighting that one if we can really come to some consensus to file a report that will have that kind of conclusion. That's all I was trying to say.

**Mr. Chairman:** I should indicate to the committee at this point that Mrs. Campbell is substituting for Mr. Blundy. I have been advised of that. All other substitutions are the same, as I understand it.

I gather that the NDP position paper is as reported last Wednesday. The Conservative position paper is the same. Mr. Conway, you have a change. Would you like to indicate that?



**Mr. Conway:** When I left, I handed the clerk of the committee a report to which I had added some words. It may not have been particularly clear. Over the course of the intervening days, we have simply decided to amplify one part of the three-point report we were favouring. I think everyone has the statement. It is the one page dated May 16, 1979. We would simply clarify 1(a) by adding the words "that no transfer take place until such a plan has been submitted by the Minister of Health to the social development committee."

Recommendation 1 then reads: In that we believe the inpatients of Lakeshore Psychiatric Hospital should obtain the benefits of a more modern facility, we recommend that these inpatients be transferred to Queen Street Mental Health Centre, provided (a) that the transfer can be accomplished in an orderly, well-planned fashion and that no transfers take place until such a plan has been submitted by the Minister of Health to the social development committee."

Everything else remains as on that statement.

**Mr. Kennedy:** On the amendment just put forward by Mr. Conway, we did discuss this in the steering committee. It bothers me because of the sensitivity of the move of patients. Although it is administrative admittedly, it is based on the head of each of the hospitals. Due to the sensitivity, I don't think it's really in the best interests of the patients that this be done. If the medical profession says that a certain number move on a certain date, I don't feel competent to say, "No, you shouldn't move 20; you should move 15."

It also concerns me about what might be the attendant publicity, which again wouldn't be in the best interests of the patients. We were quite happy with the motion as it stood. Possibly there could be some language change that would alter that a bit and make it more acceptable to both sides, but it certainly concerns me that the game plan that might be three to four months ahead now be filed. I don't know what the outcome of that might be and the impact of it worries me, Mr. Chairman.

**Mr. Duszta:** A point of clarification: May I ask, Mr. Conway, does it mean that in the next six months, the next two years, each time there is a change proposed to the hospital, you would have to come back to the committee and the committee would permanently be responsible for it?

**Mr. Conway:** The intention of the clarification was as follows: we sat down and we looked at the actual wording and import of

1(a) and (b). We did agree in principle with the notion of the transfer of inpatients. This was a point of differentiation between yourselves and ourselves and we had to change that. We felt we wanted, as a group, to have that submitted to us, to ascertain exactly how and when they were going to effect the transfer under the conditions.

**Mr. Duszta:** Mr. Chairman, I imagine how it would work. I suppose we should try to understand the amendment, because I thought in some sense the two groups had moved towards some understanding. Does this mean in the next two weeks, next two months, the minister comes and brings an operational plan and shows it to us, or is it because we have to vote on it again, or what?

**Mr. Conway:** I think we firmly believe that the ministry must have, or will certainly be forced to have, some kind of future for its operational plan, to effect such transfers as Queen Street can accept. We want to see that as soon as possible and before it is proceeded with.

**Mr. Chairman:** And that no transfer would take place until that plan is submitted?

**Mr. Kennedy:** Mr. Chairman, I was assuming we were working to the September 1 date, and that it would be staged over that period of time and subject to the report on November 30, which to me seemed adequate. The ministry has said that there wouldn't be a transfer until space was ready.

**Mr. Conway:** I brought to your attention the phrase "for examination and discussion." Maybe that wasn't as clear as it should have been, but those words were there for a reason. In (b)—and this is really what we are amplifying; I draw your attention to point (b)—"that the Minister of Health be required to make a report on the state of transfers for examination and discussion."

Yes, we do see this committee as having a mandate to pursue this particular policy along the way. We felt that once this committee had decided that from our point of view we can live with the transfers in terms of the actual policy, what we are saying, and what we wanted to make very clear in this particular phraseology, was that clearly the ministry should have, or must have, again to use your phrase, an operational plan. We want to see that. We want to see that; as far as I am concerned, we want to see it as quickly as possible.

**Mr. Duszta:** What do you want to do with it? I mean in effect you have accepted—it seems as if you have accepted the idea that the hospital must be closed and the

patients moved, as you put it, for better treatment, to Queen Street. Why have this in effect? I mean to say, no or yes?

**Mr. Conway:** No. Since we do expect to be in this committee months from now to assess the transfer on the basis of examination and discussion, we felt that process would mean much more if we had the plan. Dr. Duksza, that is really the point, from our caucus's view. The committee would have to meet in the fall to see what had happened. It was an oversight on my part to not anticipate that for purposes of that examination and discussion we should have the plan that the ministry was going to proceed with over the course of—

[2:45]

**Mr. Duksza:** How can you agree on one hand that by September the ministry can transfer, and then go into this? It's like having your cake and eating it.

**Mr. Conway:** No, no, you misunderstand me. We have indicated no dates in our position outside of November 30, 1979.

**Mr. Duksza:** Would you, for example, agree that there should be no transfers until the operational plan is produced in 1981?

**Mr. Conway:** Oh, no, our time frame is obviously much more sharp than that.

**Mr. Duksza:** I was just hoping.

**Mr. Conway:** Quite frankly we feel that to the degree there is air-conditioned space at Queen Street it should be taken advantage of, under such conditions, as soon as possible.

I make no bones about that. That's the frame in which we are working. At any rate, that is the reason for it; it was simply in the light of our insistence on the examination and discussion no later than November 30. We felt that it would be more useful to call upon the ministry to produce after the deliberations of this committee's—

**Mr. Duksza:** But if you have an operational plan like that, a necessity for producing it in this committee, that means the transfers stop basically. I mean, that's the implication of it.

**Mr. Conway:** That's not our understanding or the implication. It's there for you to—

**Mr. Duksza:** So all the ministry needs to do then is to file a report and the transfers go ahead, since you really support the basic closing of Lakeshore.

**Mr. Conway:** All we are saying in this instance, Dr. Duksza, is simply that the ministry has our support to transfer such inpatients from Lakeshore Psychiatric as

clearly space allows for at Queen Street. What we are saying is that we want to understand, and we want to have in our possession as soon as possible, from the minister himself, the operational and logistical characteristics of that transfer. That's the intention. It's no more and no less than that.

**Mrs. Campbell:** Mr. Chairman, I think I share Mr. Kennedy's concern in that the patients are the ones that we are concerned about. It's just unfortunate that the ministry proceeded to make a decision—I think the evidence bears it out—without any kind of planning at all. It seems to me, if you look at the second clause, when we require a report to be filed we are saying that the ministry put this whole thing in jeopardy; it's the ministry that did it. What we are saying is that this plan that has to be filed for discussion in this committee must be here for that discussion before any further transfer takes place. It's a shame if anyone is misinterpreting what we are saying. The plan very clearly has to be made. Perhaps it's a good exercise for the Ministry of Health—

**Mr. Duksza:** I'm a simple shrink—I don't understand lawyers.

**Mrs. Campbell:** I did not interrupt, Dr. Duksza, May I proceed, Mr. Chairman?

**Mr. Chairman:** You may.

**Mrs. Campbell:** It seems to me that it will be a useful exercise for the ministry. I don't think they have ever planned; I don't know whether they have a planner within the ministry. But there were all sorts of implications in the evidence before this committee which indicated very clearly that there needed to be a plan filed for discussion. We said that; there was no question about that's what we said. I think the hiatus was that we did not relate it to the timing of any transfers.

Now, as far as I am concerned—I don't frankly know, and I am not an expert in patient care—when we look at what the doctors from Queen Street said, when we look at the other evidence, it's quite clear that we need to know a great deal more than we now know as to the implications.

I don't know why it is misunderstood, to be perfectly honest with you. We are not prepared to move anybody until the plan referred to in our second point is before this committee for discussion. How you can say that we're going to have an ongoing, day-to-day kind of thing is beyond me. I think that's a red herring.



It does seem to me that the reasonable thing, if we are concerned about the patients—and I would put that to Mr. Kennedy—

**Mr. Kennedy:** We're with you there. We part company in other areas.

**Mrs. Campbell:** —is to ensure that the ministry also has that concern for patients, which we haven't seen from the evidence before us.

**Mr. Kennedy:** There is an inpatient committee, as we know, and I have full confidence in it.

**Mrs. Campbell:** You may.

**Mr. Chairman:** Mr. Sweeney, Mr. Johnston, Mr. Rowe and Mr. Lawlor are on my list. Mr. Duksza, you had a point of clarification.

**Mr. Duksza:** Would it be possible, Mr. Conway, to move this as a separate motion?

**Mr. Conway:** On that point, I want to make it clear so that everybody understands it. I'll read it back into the record because there seemed to be some confusion. "1(a) That the transfer can be accomplished in an orderly well-planned fashion and that no transfers take place until such a plan has been submitted by the minister to this committee."

**Mr. Duksza:** Then it's a new motion. Why don't you introduce this as a motion and a report separately?

**Mr. Conway:** I don't want to say any more at the present time other than to suggest that from our caucus's point of view we were prepared today—and we did in the steering committee—to introduce again our three points with that one particular amplification. How you want to deal with the actual writing of the report—

**Mr. Duksza:** But the implication is in content quite different. If it was a separate motion, it would be easier to discuss and we could then vote on it. Then there would be a report from the committee with a dissent, if there is any, and then the motion from Mr. Conway very specifically giving an instruction separately.

**Mr. Conway:** It was my private hope that we would begin with one of the position papers which had points. I was quite prepared to start with ours and submit it point by point to see what, if any, voting consensus there was for it.

**Mr. Chairman:** Perhaps on that point we can carry on the discussion a little further to see if there is any possible consensus emerging. If there isn't, perhaps one or another can make a motion, we can vote on

it and then carry on. Would that be satisfactory?

**Mr. Sweeney:** To pick up the previous discussion, if we're still on it—

**Mr. Chairman:** We're still on it.

**Mr. Sweeney:** —the point we were given to understand by the minister when he first appeared before us was that there was an overall plan of action to transfer at least the inpatients from Lakeshore Psychiatric Hospital to the Queen Street Mental Health Centre. As the hearings went on, we heard from several people, particularly the union people and the doctors at Queen Street themselves, that either that plan was flawed or that it was not a complete plan. It was one of the two and there were variations on that.

We have made it very clear that we approve of the transfer of the inpatients, but we also made it pretty clear during the discussions, by the way, in which we questioned people and by the comments that were made, that there were at least three components, among others, of that transfer that would have to be identified clearly.

The first one was that the facility was there for them; that the space was there and properly set up for them; and that it wasn't some makeshift arrangement.

Second, we wanted to be sure that the staff would be there; that whatever transfer of staff from Lakeshore had to take place or whatever new staff had to be found, whatever the case might be, adequate staff would be there.

Third, and just as important, whatever displacement was going to occur at Queen Street should occur in such a way that the patients and programs that were already there would not be affected.

Basically, all we're saying is that if the minister has such a plan, as he says he has, then he should lay it before us. We suspect by the way in which the operation has occurred that such an overall plan has not been clearly identified. Therefore, we are saying to him, "If our suspicion is correct, then put together that plan as quickly as possible, using all those various components, and lay that before us. Do not move one more patient until it's all put together."

That seems to be a pretty reasonable position, given our starting point obviously. I think it flows logically and naturally from the hearings to this point.

**Mr. R. F. Johnston:** I would just like to say that I think this is window dressing and it is not a very useful direction at all to go in. The fundamental question is whether or not the inpatients should be moved at all.



To have us as a committee looking at a particular specific administrative procedure is not useful. We already know there are people talking and meeting about how this will be effected. Geriatrics have already been moved. There is a group ready to go, presumably, by May 30. This begs the initial question and to me it is meaningless. My position hasn't changed one iota at all.

**Mr. Rowe:** My concerns have been expressed just now in part by Mr. Johnston and also by Dr. Duszta. The question is why report to this committee? It was my understanding that these inpatients were to be transferred by September 1 and there is a plan in progress. As Mr. Johnston just expressed, there is certainly planning going on. They aren't just moved on someone's overnight decision to pack up half a dozen more tomorrow morning and move them in that way. I am sure there is intelligent planning going on.

That brings up a question. I hate to think of politicians getting involved in technical—if I could use that word—business. I think the question is why would they report here. If I had a relative in that institution, I would rather leave that relative in the hands and at the decision of a professional who knows something about it than in the hands of a politician who, quite frankly, knows nothing about it per se.

My answer to Mr. Conway's amendment to the Liberals' original position, where the transfers will not take place until a plan is tabled here, is that I just can't go along with that. The decision is shall they be transferred or shall they not. There seems to be a majority opinion that they should be transferred and that the transfer does take place. As to how it takes place, I think the details can better be worked out by the doctors and the psychiatrists involved and that the transfer should not be interfered with and held up again. They say a camel is an animal put together by a committee. I am afraid that is just exactly what this sort of result would be if a group of politicians got into it.

**Mr. Chairman:** Could I complete the list and then we will break? Mr. Lawlor and Mr. Pope are the only remaining two. Then we can break for five minutes.

**Mr. Lawlor:** This points up the fundamental issue. The pith and substance of our position is that there are only 120 patients left in the hospital. They have moved a very considerable number already. As far as the inpatients are concerned, with the affirmation of the basic government position the

cat is out of the bag and any amendment or change is adjectival to the main issue.

The second thing has to do with the plan. I suggest to you—and I go along with you, Mr. Rowe—that we can be very easily bamboozled. They produce a plan. So what? Where do we go from there? Suppose we did disagree with it and suppose a substantial number of members thought it was inadequate in the context, there are no sanctions to that. They just hand you a piece of paper and go right ahead. I don't see how efficacious the thing is. What I do think is that the amendment muddies the water.

[3:00]

We had division enough and sufficient acrimony thereto with respect to this first clause, which is the central issue. This added thought, as I say, doesn't do anything to promote any degree of agreement as far as that's concerned.

I would ask the Liberals to do one of two things: take it off with somewhat amended wording as a separate motion, as has been suggested by Mr. Duszta; or abandon it.

**Mr. Pope:** I understand that Mr. Conway is amending the Liberal position paper. I am just addressing myself to the amendment if we are trying to reach a consensus amongst us for the filing of a report.

It was my understanding that there is an inpatient transfer committee composed of both medical directors and the director of nursing. They are making decisions on the timing and the numbers of transfers. If the ministry was to ask them to file a report with this committee, I think the only one that could determine whether or not their plan was in the best interests of the patients would be Dr. Duszta.

**Mr. Duszta:** That's nice.

**Mr. Pope:** You see, I do give you some credit. None of the rest of us would be in a position to challenge the professional opinions of the people who are involved in the inpatient transfer committee. I'd have to agree with my colleague, Mr. Rowe. If the transfers are in the hands of these gentlemen and they have the expertise, I'd prefer to see it left in their hands.

**Mr. Conway:** Mr. Chairman, on that point, maybe I can clarify one or two things from just listening to the discussion. The first has to do with the comment about our ability as a committee to make judgements.

I am absolutely flabbergasted to hear so many aggressive types from all sides of the room advertise what I really didn't imagine was such a thorough-going impotence on

these matters. It may be that we are not competent to do this and a lot of other things; it's not for me to say.

We did phrase 1(a) somewhat differently in the light of two things. One was our own consideration of its import in the light of what we wanted to do. Second, as I indicated earlier, the injunction from the Clerk's office was passed on to us after this committee met last Wednesday. I just make those two points. If you want to recess for a short period, that's quite all right with me.

**Mr. Chairman:** We'll adjourn for five minutes.

The committee recessed at 3:04 p.m. and resumed at 3:10 p.m.

On resumption:

**Mr. Chairman:** I call the committee to order again. I would hope that we wouldn't spend a lot of time on this. It's pretty obvious that there really is no consensus. I am seeking for direction from the committee.

**Mr. Lawlor:** I am going to suggest something. We could spend a great deal of time this afternoon and come out at the end rather disgruntled without having achieved any further progress really. Why not write a report along the following lines: First, that the committee agrees that the property should be retained in public ownership.

**Mr. Chairman:** That's not contentious; that's agreed.

**Mr. Duksza:** That's the minister's policy anyway. He said so.

**Mr. Chairman:** Yes.

**Mr. Lawlor:** Second, that a majority of the committee agree that the inpatients be transferred to Queen Street. Then we come to the next sentence. The Liberals have submitted a refinement upon this basic proposition. We add here the time limitations and the clauses that are under discussion on whatever the Liberals wish to put in. Then we would add to that clause that for the reasons given in an appendage report we would reject this out of hand and believe it is unwise and a most fallacious move on the part of the government.

[3:15]

Third, you get to the outpatient situation, that the committee by a majority—we could discuss that, or even possibly agree—recommend to the minister that the patient services be retained on the site at the Lakeshore, at the present facilities. The other wordings that we have before us “are in the community.” If it should come out that the majority agree to “in the community,” I

would ask that the New Democrats be able to put in one sentence, saying that they stipulate that the outpatients be on the site.

Then as we get down into the other areas, there is less disagreement. I think it could probably be resolved with some of them. The Liberals' position on the next point would be with respect to a survey being conducted within a fairly narrow time span, to be reported back to this committee and to receive our surveillance of that particular time. If it's going to happen, at least it has been carried out, and they have set up a plan that has been recommended to us by everybody who appeared before the committee with respect to community care in that area.

Then we are all concerned about the employees and their position basically. The majority of the committee at least agree that the best available and every effort be made to retain on staff and to accommodate employees being laid off in this particular regard. I would—you may as well know the position—go to the next sentence, and say the New Democratic Party members, believing that it shouldn't be closed at all, think there would be no necessity for anyone to be laid off.

That would be the report, as I see it.

**Mr. Conway:** On a point of order, Mr. Chairman.

**Mr. Chairman:** Mr. Conway.

**Mr. Conway:** The member for Lakeshore has in his unique way struck out a rather general and interesting proposition. I am not unprepared to consider it. I would suggest that he make some effort to put it on a draft form, so that we could use it for purposes of debate. I would want to speak on behalf of my colleagues. That's the sort of rather comprehensive approach to consensus formation that would require, in my view, another recess for us to assess the actual import of the individual aspects. Mr. Lawlor has made an interesting interjection which we would be most anxious to consider under those conditions. That's my point.

**Mr. Kennedy:** I think Mr. Lawlor touched on many points that are contained in this combined one, where we put the PC and Liberal positions together. Certainly in some of these sections we are in agreement, if I recall correctly. This is on the table, and I would wonder if there is any merit in having another go at it, or have Mr. Lawlor draft it up—I would agree with Sean, we would want to see it in draft.



There was one point on it, Pat, where you mentioned maintaining outpatients in the community. In the overall study of the committees, and so on, they might have an adjunct or one of the services in Mississauga. That's just splitting hairs on it, but it's something that caught my ear as you were speaking.

Is there merit, Mr. Chairman, in discussing this? Otherwise, we have got to wait for a rather lengthy draft from Mr. Lawlor, I would suggest.

**Mr. Conway:** I would be most interested if Mr. Lawlor could draft something to provide to us, in a reasonable time, if it's at all possible—

**Mr. Lawlor:** I hear some whispering from my colleagues. I think we would want again a few minutes to discuss this matter before I go on to some kind of bloody abortive drafting.

**Mr. Conway:** Mr. Chairman, he is asking to have some desire on all sides for some consensus formation. I do recognize this does take some negotiation privately and publicly. We had better be prepared, if that is our desire, to live with it. I certainly would like to see Mr. Lawlor's draft.

**Mr. Lawlor:** Let me have a talk with my colleagues first.

**Mr. Chairman:** Is it the wish of the committee that we take one more run and I suggest perhaps this be the final run, that if we can't do it this time, then we submit three separate reports. Is that agreed? It will recess for 15 minutes—

**Mr. McClellan:** Four minutes.

**Mrs. Campbell:** It will be longer than that, if in fact, Mr. Lawlor does want to reduce this to writing. It certainly can't be done in four minutes.

**Mr. Chairman:** No, indeed it can't. No, no, I never suggested four minutes, Mrs. Campbell. I was thinking in terms of 15 minutes or half an hour. Would we reconvene at four o'clock? If it becomes apparent that we are going to fly apart again on it, we will move to submit the three reports as we—

**An hon. member:** An excellent move.

**Mr. Chairman:** All right, adjourned.

The committee recessed at 3:20 p.m. and resumed at 4:35 p.m.

**On resumption:**

**Mr. Chairman:** The committee has before it Mr. Lawlor's proposal, and I'm wondering if there is any agreement that we can come to some consensus around this proposal. If we can, I hope we can do it quickly. If not,

we'll have to go back to our original position of issuing three statements as part of the report. Mr. Conway?

**Mr. Conway:** Speaking for our caucus—and I regret we did take a little additional time, but we did want to give it a thoughtful review—in general, the statement of Mr. Lawlor's is agreeable to us in points one and three, the first sentence of four and five.

Point two is something that we suggest would be effectively dealt with by the articulation of a dissent and that that particular section simply be worded in such a way as to indicate the committee could not agree or agree to disagree, with comments appended in a dissenting form.

In terms of the five points, our caucus would accept point one and point three, although we've got just a question of wording there; we don't believe it is major, but it is a concern. In point four we agree with the first sentence, and we would just suggest that the second sentence as it's worded is a dissenting opinion that could be included as part of a New Democratic dissent. We would accept point five.

From our point of view, we would envisage a report, if we seek one on the basis of consensus, which would accept those points of Mr. Lawlor's and simply append dissenting opinions by the individual caucuses. We certainly have one, which would basically put our position on point two.

**Mr. Kennedy:** Do you want that sentence deleted then?

**Mr. Conway:** I'm talking now in general terms. For example, just on the wording, we would have to take the wording of point one. The things we can agree on, obviously, we have to word in such a way that the committee agrees, recommends, affirms, or whatever kind of phraseology we can agree on.

On point two, which is the major point of disagreement, all I might suggest is at this point the committee could not reach agreement on the question of inpatient transfers, or whatever you want to characterize that as, and dissenting opinions are appended to explain the individual positions.

**Mr. Rowe:** Do you agree on point two up to "November 30, 1979"?

**Mr. Conway:** We looked at point two, Mr. Rowe, and we just feel that it would be easier to state the positions by dissenting opinions. It becomes very awkward to try to piece together bits and pieces. Our position on point two is that we would like to express our position in our own language. But on the other four points there is agreement in whole or in part.



Mr. Lawlor, for your purpose, on point three, "that all existing outpatient services presently connected to Lakeshore hospital be retained on the site," our caucus felt that the language of our initial statement, that "outpatient services presently connected to Lakeshore hospital," was a preferred phraseology.

Mr. Rowe: Or leave out the words "on the site," period.

Mr. Conway: Yes.

Mr. Kennedy: We agree with you on that.

Mr. Conway: All right. But in general terms, if you want to just get our impression of the document, Mr. Lawlor, that would be our response. We just felt very strongly that there should be a catch-all dissent, if you wish, so that each caucus could express itself in one or two or three points about how it felt with the areas of dispute.

Mr. Chairman: Mr. Rowe, and then Mr. Lawlor.

Mr. Rowe: The sentence which ends "November 30, 1979," I understand is the basis of general agreement there. Then the other two sentences could be classed as two dissenting opinions, one by the Liberal caucus and one by the NDP caucus. Is that not right?

Mr. Conway: We were going to dissent on point two, Mr. Rowe. We just felt that it would be simpler and more useful to register that at the outset and proceed with a statement of the individual caucuses outlining the positions as they report.

Mr. Kennedy: Are you saying then, Sean, to delete everything after "November 30, 1979"?

Mr. Chairman: No; to delete point two. As far as Mr. Conway's position is concerned, point two comes out and a dissenting view-point goes in.

Mr. Sweeney: In fact, there's no agreement on point two.

Mrs. Campbell: That's right.

Mr. Sweeney: When you come right down to it, there are three positions.

Mr. Pope: Except the first sentence in point two is the wording from your own brief.

Mr. Lawlor: Directly from your brief.

Mr. Conway: What concerned us essentially was the flow of the whole thing in point two. I understand that certain words in there are very familiar. But it leaves an impression, with things appended on both sides, of a majority which is very unclear.

I draw your attention to the earlier debate. Our position on point two is point one in

our document. The government caucus indicated that it could not accept, for its stated reasons, that position. My impression earlier of the New Democratic position was that it couldn't accept that either. So we just felt it would be more sensible and more useful to deal with it directly in a straightforward statement of position by each of the caucuses on that question.

Mr. Rowe: It's simpler to put down what we agree on, which is the first part of that.

Mr. Conway: You can't accept the proviso in our point 1(a), as I understood it. Correct me if I'm wrong, but in our point 1(a) we say that there can be a transfer, "provided (a) . . ." If you can accept that proviso, then that's a different matter. I understood Mr. Kennedy's earlier position as being hostile to that proviso.

Mr. Pope: You're talking about the amended one.

Mr. Conway: That's right.

Mr. Kennedy: The amendment bothers me.

Mr. Conway: I understand that, and that's the reason for it. Mr. Rowe, just coming back to your point, the key words are "provided (a)," and Mr. Kennedy indicated that was difficult.

Mr. Rowe: "Provided (a)" is in that first sentence of point two.

Mr. Pope: No.

Mr. Conway: We didn't feel that it was quite the way which we had intended it.

Mr. Pope: They have amended it since.

Mr. Chairman: Mr. Lawlor?

Mr. Lawlor: You wouldn't consider in the second sentence—before I do that, let's get to some typographical stuff. On page two, in point four, in the fourth line, following "be given to these employees," I meant there to be brackets around "including management employees," and not dashes, that particular point. These are minor matters. Then, in the next sentence, after "Since the members of the NDP do not agree that any employees need to be laid off," there should be a comma, followed by "and since these members . . ."

In point five, the word should be "out-patient" in the third line; and in the second from last line—I don't want to sue anybody, not this afternoon—the word should be "used."

To return to the nub point here—

Mr. Sweeney: Can I just ask one question, Mr. Lawlor, before you go on? The last phraseology in your second statement, "in our appended dissenting opinion," is that

going to be in the same statement you had previously?

Mr. Lawlor: It should be "their" to start with. It shouldn't be "our."

Mr. Chairman: Yes, that's right.

Mr. Lawlor: We're dictating it from my point of view.

Mr. Sweeney: Yes, but the last sentence refers to the NDP position.

Mr. Lawlor: Yes.

Mr. Conway: Therefore, we gathered that "our appended dissenting opinion" referred to the NDP dissenting opinion.

Mr. Lawlor: Yes. When you put in the word "their," it's referring to the NDP. Do you want me to put it in brackets?

Mr. Conway: No, no. I just want to be sure I understand that what you're referring to is the opinion that you have previously printed.

[4:45]

Mr. Sweeney: And that's going to be appended.

Mr. Lawlor: Yes. I want to suggest that we do the same thing for the Liberals. Then the second sentence should say the Liberal Party wishes to state that no transfers take place until the plan is submitted to the committee by the minister. Then we can refer the House to our appended dissenting opinion or something like that.

Mr. Conway: Mr. Lawlor, you then come back to accepting the majority. From our point of view, that's a provisional majority. There is agreement between the government caucus and ourselves on that point, provided the government accepts that. If that provision is met, then there is a majority; if it is not, there is no majority. That's the point that we were making there which has to be clarified.

Mr. Rowe: Do you mean the majority and a firm position?

Mr. Conway: I should have highlighted the word "provided." It was there for a reason. I wanted to indicate that from our point of view there is agreement with Mr. Lawlor's document on four points.

Mr. Chairman: What about the Conservative caucus? Mr. Kennedy, can you accept the four points essentially?

Mr. Kennedy: Yes, with a motion that "on the site" be deleted in line two of point three. At the present time there is the DARE program on Horner Avenue and it would reduce the flexibility of perhaps finding a better location more suitable for such programs. If the committee could agree to de-

leting the words "on the site" after "be retained" and before "and, further, that these community services be expanded," that would accommodate us. That's the only thing we are really hung up on in the whole report.

Mr. Lawlor: Let's try to reach some accommodation on that. I knew you were going to insist upon "in the community." I would like to add a sentence stating "The New Democratic Party believes that it should be retained on the site."

Mr. Chairman: That's fair enough.

Mr. Kennedy: Yes. That's acceptable.

Agreed.

Mr. Chairman: We've got acceptance of points one and three.

Mr. Kennedy: Of point three as amended.

Mr. Chairman: As amended. We have got acceptance of four, as amended, up until "alternative employment."

Mr. Conway: Would you suggest that that then become another dissent, Mr. Lawlor, if that's agreeable?

Mr. Lawlor: I am sorry, I don't understand this.

Mr. Conway: Our point on four is that we accept your first sentence entirely. Then we are suggesting the dissenting opinion be included in your list of dissents.

Mr. Pope: In your document.

Mr. Conway: In your own document. We are thinking of a report that states the areas of agreement and then the caucuses are free to express their dissents on such opinions.

Mr. R. F. Johnston: Then the word "majority" again should be included in that sentence. It would read: "The majority of this committee recommends that all existing outpatients," et cetera.

Mr. Lawlor: I am not quite happy with it for the same reasons you are giving on point two.

Mr. Conway: It's assumed, is it not, that the phraseology is the one I would expect to be using, namely "that the committee recommends"? That's the language we use to express a majority.

Mrs. Campbell: That's right.

Mr. Conway: Where there are dissents, then they are registered.

Mrs. Campbell: That's right.

Mr. Sweeney: I have one concern. I seriously question the use of the word "majority" anywhere in here quite frankly. I think it should be "that this committee."

Mr. Chairman: There's no problem there. If the committee agrees, we don't say "the majority" here.

Mr. Sweeney: You don't say "the majority." The proper language is "this committee."

Mr. Chairman: We have got agreement on points one, three as amended, four as slightly amended and I presume on five.

Mr. Lawlor: On point five, for instance, I put in "majority" because we have a refinement on the period of time involved, on the two-year business. We have been suggesting a shorter time than that. In our dissenting opinion we have set that out as to what we think those time limitations might be, 18 months at the very most.

Mr. Sweeney: If the statement says that the committee agrees, and then there is a series of dissents, that covers it. It's improper to use the word "majority" anywhere.

Mr. Chairman: That's right. This is only a discussion piece, Mr. Sweeney.

Mr. Sweeney: Yes, but I think it's a key issue.

Mr. Chairman: I agree.

Mr. Conway: I want to make it clear to Mr. Lawlor, if he is indicating now that that is an 18-month time period, my understanding initially was a six-month period. If it's 18, then we are much closer together.

Mr. Lawlor: Six months.

Mrs. Campbell: Eighteen months is—

Mr. Conway: Eighteen months is quite agreeable with us if that's being suggested in point five.

Mr. Chairman: Is that the suggestion, 18 months?

Mrs. Campbell: That's Mr. Lawlor's suggestion, isn't it?

Mr. Lawlor: Mr. Lawlor has amended it to six months.

Clerk of the Committee: To six months?

Mr. Chairman: To six months?

Mr. Conway: Months. Then we would accept the two years since that was our language, I think, in the first instance.

Mrs. Campbell: It'd be very difficult to do it at six months—

Mr. Chairman: That would go as the committee recommendation, and Mr. Lawlor's dissent would be so indicated.

I think we have made some progress.

Mr. Conway: I think in point two it would be just useful, perhaps, to indicate that the committee could reach no agreement on the—

Mrs. Campbell: No consensus.

Mr. Conway: No consensus, no agreement, whichever one would prefer, on the matter of inpatient transfer and that the opinion of the three parties are as appended in this report.

Mrs. Campbell: Hereto.

Mr. Conway: Or hereto, or some such thing, and it gives everyone the opportunity to just put their cases clearly as they can. That would be my suggestion, but I am open.

Mrs. Campbell: Yes.

Mr. Chairman: Agreed?

Agreed to.

Mr. Chairman: Could we leave it this way: I think the clerk and I have a general sense of what is being attempted; could we re-draft this and circulate it tomorrow morning? If it's agreeable to the parties, then I'll file it in the Legislature tomorrow.

Mr. Conway: So there is no misunderstanding, Mr. Chairman, we will submit to the Clerk's office, no later than first thing tomorrow morning, our dissenting opinion; in our case I believe it is just a question of point two. We will make that available first thing in the morning so that it's part of the draft circulated.

Mr. Kennedy: Let me try again. We are going to say there has been no agreement on the inpatient transfers.

Mr. Conway: That's right; it's on transfers.

Mr. Kennedy: Okay.

Mr. Sweeney: And the three opinions are appended.

Mr. Chairman: That's right; and the three party statements are appended herewith.

Mr. Kennedy: Hereto. Yes, okay, that's fine. And we'll probably put in our first item from our original thing, which deals with us and makes reference to Hamilton, and so on.

Mr. Chairman: That's fine, okay. All right. Agreed?

Some hon. members: Agreed.

Mr. Lawlor: Hold it for a moment. On point four I am still not in agreement. I am willing to cut down that sentence. Our position is that the hospital shouldn't close, and therefore there is no necessity for laying off employees. That is so salient a feature of the thing I wish to insist on some mention—apart from the very vague wording—of our dissent, which they may never get around to looking at.

Now, I am willing to cut the sentence down, but I am not willing to take that out completely.

Mr. Rowe: It's more important—



**Mr. Lawlor:** Particularly if you say, "this committee," and knock out "the majority."

**Mr. Chairman:** That's right. Well, that comes out.

**Mr. Conway:** Mr. Lawlor, our position with respect to your statement or your phraseology on point four is that you will exercise every entitlement to state, as strongly as you wish, the import of the second sentence in a dissent.

**Mr. Lawlor:** But I don't want to make a bare reference to some nebulous dissent. I want to give some indication in this instance what the dissent consist of.

You see, I can strike out the phrase, "since the NDP opposes the closing" as such, but I want to make it clear that in the NDP dissenting opinion it sets up their grounds for believing that no employees need be laid off, and let it go at that.

**Mr. Conway:** But I think that's the nature of a dissent, is it not, Mr. Chairman?

**Mr. Chairman:** Yes, I think there are a number of ways that one can do it, Mr. Lawlor. You can incorporate it in your dissent to point two, where you state clearly that in your view the hospital should remain open, that the inpatients, the 120 who are presently there, should stay there and that hence the employees employed by the hospital should remain as is.

**Mr. Lawlor:** But I am not willing to give an iota of credence to accepting the closing. This particular clause takes it as though it's an accomplished fact, and says, we bow our heads before it and ask them to be nice fellows and keep as many people in their jobs as they possibly can. That ain't good enough, for me at least.

**Mr. Chairman:** I can see your point, and of course your position throughout has been consistent in that respect.

**Mr. Lawlor:** Yes, and I want to say so in the main document.

**Mr. Chairman:** But it's a question of how one does that within the confines of a report, a report which is filed on behalf of the committee and which includes a dissenting report.

One of the items on which you dissent, obviously, is the key question of the closure. You don't want the closure, period, and the things that flow from that are rather obvious, one of which is the fact that the employees remain as is and are kept at the hospital.

Now, how you wish to do that I suppose is up to you in this way, in that you are filing a dissenting report from the committee and in that dissenting report you can include anything you wish to include. But if you are

saying on point four that you then move on after "alternative employment" to state that the NDP is opposed to the closing and that no employees therefore should be laid off, that, in my view, constitutes a dissenting opinion.

**Mr. R. F. Johnston:** I think from our perspective it's a matter of emphasis. I do not equate the Liberal proviso with our outright denial of the closure. I just don't think that those things are on a par. My wish would be that we could use the same kind of structure we have here; that is, have each dissent registered behind the majority opinion all the way through and not just have them tacked on to the end. It would offend me a great deal to look at the substance of what would be our recommendation, a full page of everything that I don't believe in and then at the end have tacked on the dissent. The dissent is too important to me.

**Mr. Chairman:** That's no problem.

**Mr. R. F. Johnston:** And that's the structure I would like to see.

**Mr. Chairman:** That's no problem. All we say is: "The committee strongly recommends that the employees at Lakeshore hospital be retained to the fullest possible extent and that every assistance be given to these employees, including management employees, in locating alternative employment. Dissent: the NDP." That's no problem.

**Mr. Conway:** Will you accept the suggestion that the chairman and the clerk, having the statements of dissent as they are provided in language that is agreed to by the caucuses, take these to the steering committee for tomorrow morning?

**Mr. Chairman:** Perhaps it would be better to expand that to the steering committee, and we meet tomorrow morning at, say, 10 o'clock and every dissenting position of each party should be in the hands of a steering committee member, that's all.

**Mr. Conway:** Mr. Chairman, I remind you, I believe we have a caucus tomorrow morning.

**Mrs. Campbell:** So does everybody else.

**Mr. Conway:** So 10 is an inappropriate hour.

**Mr. Chairman:** Let's make it 12:30 and do it at a luncheon meeting.

**Mr. Conway:** That's fine. Agreed.

**Mr. Chairman:** It's not good for digestion, but is that agreed?

**Mr. Conway:** Can we then agree with the idea that the chairman, the clerk and the

representatives from the steering committee meet in the dining room for lunch to work this thing out?

**Mr. Chairman:** That's right.

**Mr. Rowe:** Why don't you reserve one of the little rooms?

**Mr. Conway:** That's fine.

**Mr. Chairman:** We can do that, so it would be Mr. Kennedy, Mr. Conway, Mr. Lawlor and the clerk and myself.

Okay? Tomorrow at 12:30.

The committee is adjourned, unless there is any further business.

The committee adjourned at 4:59 p.m.

### SPEAKERS IN THIS ISSUE

---

Breagh, M. (Oshawa NDP)  
Campbell, M. (St. George L)  
Conway, S. (Renfrew North L)  
Dukszta, J. (Parkdale NDP)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Kennedy, R. D. (Mississauga South PC)  
Lawlor, P. D. (Lakeshore NDP)  
McClellan, R. (Bellwoods NDP)  
Pope, A. (Cochrane South PC)  
Rowe, R. D. (Northumberland PC)  
Sweeney, J. (Kitchener-Wilmot L)



No. S-18

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Monday, May 28, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

MONDAY, MAY 28, 1979

The committee met at 3:49 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

**Mr. Chairman:** I call the committee to order. As the committee realizes, we are commencing our hearings on the hospital bed-cut program of the ministry. The minister has an opening statement.

Before we get into that, I should review the substitutes for today. I presume these will pertain throughout. I am acting on that assumption. If not, please correct me.

Mr. R. F. Johnston for Mr. Cooke; Mr. Cassidy for Ms. Gigantes; Mr. Breaugh for Mr. Grande; and Mr. Conway for Mr. Kerrio. Those are all the substitutions I have.

**Mr. Cassidy:** I am in for today and may be in for future days, but—

**Mr. McClellan:** We'll correct the thing as needed.

**Mr. Chairman:** Okay, fine, we'll play it by ear.

**Mr. McClelland:** As always.

**Mr. Conway:** Mr. Chairman, on a point of order, if I might. Two things: one is I have an addendum to the Wingham brief, but I do not as yet, I believe, have the brief.

**Mr. Chairman:** Oh.

**Mr. Conway:** It's available, that's fine. And secondly, is the minister's statement available for perusal while he reads?

**Hon. Mr. Timbrell:** It will be available afterwards.

**Mr. Conway:** But not during the course of your reading?

**Hon. Mr. Timbrell:** No. None of the copies are here yet—at least, I don't think they are. They will be available afterwards.

**Mr. Conway:** Well, you disappoint me in that connection.

**Mr. R. F. Johnston:** You had better take the satchel out of the room.

**Mr. Chairman:** Mr. Conway, just on a matter of clarification, the so-called addendum is the submission that will be made tomorrow.

**Mr. Conway:** Oh, fine.

**Mr. Chairman:** The large brief was the brief presented to the minister and his staff when the hospital was down and met with the minister in April, so it's a misnomer really.

**Mr. Conway:** I don't believe I have a copy of that.

**Clerk of the Committee:** We are getting you one of the copies.

**Mr. Conway:** That's fine. I just wanted to make sure that I could.

**Mr. Kennedy:** It says May 10. Are we talking about the same brief?

**Mr. Chairman:** Yes.

**Mr. Kennedy:** And was the date May 10 or April 10? It was presented to the minister on Tuesday, May 10.

**Mr. Chairman:** I don't know when it was prepared, but it's going to be submitted tomorrow, that's all I know.

**Mr. Kennedy:** Oh, I see.

**Mr. Chairman:** And the large brief is the one that has already been submitted.

**Mr. Rowe:** They are both dated the 10th; April 10, and May 10. Both dates appear, so I guess it's the same brief.

**Mr. Kennedy:** It's the same brief, maybe one month, or a typographical error.

**Mr. McClellan:** I don't mean to be difficult but it really is difficult for us to deal with a major and important statement from the ministry without a copy of the text. How can we be expected to respond to it with intelligent questions? And I don't see what the insuperable difficulty is in the ministry doing—

**Hon. Mr. Timbrell:** They have gone to see where they are, so as soon as they are here, David, as soon as they are here—

**Mr. McClellan:** —us the courtesy of giving us the text.

**Hon. Mr. Timbrell:** Sure, glad to.

**Mr. Chairman:** what I propose to do today is make my opening statement and then Dr. Dyer, who is the Assistant Deputy Minister for Institutional Services, will carry on the presentation on the hospital budget processes and the policies of the ministry. Unfortunately I have to leave, following my statement, to

go to Timmins to meet with the Association of Boards of Health of Ontario and open a health fair in that community, but I will be available later in the process for any questions.

I anticipate we will have questions, of course, at various stages in the proceedings, and will suggest various witnesses to come and share with the committee impressions and facts about health planning in the province.

**Mr. McClellan:** Does that mean you are not going to be available for questions on your statement?

**Hon. Mr. Timbrell:** Today I can't, that's right.

**Mr. McClellan:** That's awfully good of you.

**Hon. Mr. Timbrell:** It was either this or ask that the committee not start until tomorrow. I do have commitments made to a number of people in the province, and I am sure you would want me to keep them.

**Mr. Chairman,** over the next few weeks you will hear a great deal about the practice of health care in Ontario and the resources available to meet the needs of various communities. In view of the matter before the committee today, I would like to try to put the active-treatment bed question in perspective by giving you an overview of the state of development of our health system at this particular point in time. In this context, I will review the recent history of hospital services in the province and explain the Ministry of Health's objectives in this area.

As the members are aware, consumer demand for health services has risen dramatically in recent years. In the fiscal year 1972-73, my ministry spent an average of \$205 on health care for every man, woman and child in the province. This fiscal year, seven years later, the total will be about \$488 for every person in Ontario. Much of this increase relates to escalation of costs and new health services.

Costs of the health system—not just here in Ontario, but throughout Canada and most of the world—have risen sharply in the past few years. Today more and more people are demanding health care services, which are growing increasingly expensive to provide.

Last year, the Ontario Health Insurance Plan, OHIP, handled almost 57 million claims, an increase of more than 30 per cent over just five years before. During that time, the population increased from 7,939,000 to 8,443,800, or 6.35 per cent. Also today, the health needs of the population are changing, so what is needed and what our ministry is

co-ordinating is a concerted effort on the part of everyone involved to meet these changing health needs of our population in a fiscally responsible manner. At the same time, we must ensure that the quality of those services is maintained.

The pressure for a greater and greater supply of health services is bound to continue right through the 1980s and beyond, largely because of our aging population. The birth rate is declining, and people are living longer, and older people require a larger share of health services than their numbers would seem to indicate.

If I may, I'd just like to cite one example. People more than 65 years of age currently account for slightly less than nine per cent of Ontario's population. And yet they represent approximately 33 per cent of the patient days in our active-treatment hospitals. And their numbers are growing. Population projections indicate that by the year 2000 Ontario will have more than 1.3 million senior citizens, almost double the number we have today. So that's just one indication of the pressures that fuel demands for health care.

The response of my ministry to these pressures has been, and continues to be, long-range planning to make the health system more efficient and responsive to the changing needs of the population. At present, the ministry's management of the health-care system encompasses four major objectives: First, we are de-emphasizing acute hospital care, and placing greater emphasis on alternative lower-cost forms of health care, such as chronic- and extended-care facilities, day surgery, and home-care programs.

The second major thrust of my ministry's long range plan encompasses greater emphasis on disease prevention and community health programs. These both complement and help make feasible—I'll wait just a minute, **Mr. Chairman,** until the copies are handed out. I'm on page four.

To begin that paragraph again, **Mr. Chairman,** These both complement and help to make feasible the modification of the traditional emphasis on institutional care. More importantly, they reflect growing recognition that the significant opportunities for future improvements in health today lie in preventing rather than curing disease.

The third major thrust of our ministry is towards encouraging increased personal responsibility for health. The people of Ontario must perceive health as something preserved by way of living, rather than something restored by treatment of disease. I think this is happening more today, and to encourage this perspective the government is engaged in a



continuing public education program about health and health-related issues.

The fourth major thrust of my ministry's program is continued decentralization of planning for health care. As you know, district health councils have been established across the province in recognition of two factors: first, public interest in participating in the decisions that affect their communities and their lives; and second, the logic of sharing with local residents responsibility for planning and co-ordinating local health care resources in response to local needs.

These in essence then are the four main objectives my ministry is pursuing to shape the health system so that it meets the future needs of the province. I have expressed these objectives in general terms, but make no mistake about it, what is implied is a significant reshaping of our health system, a process of change which we are currently experiencing and indeed which we have been experiencing for some time.

I may now focus on the first objective of my ministry, which is of principal concern to this committee. That is the de-emphasis on acute hospital care, and increasing emphasis on alternatives. Before doing so, I would ask the committee members to bear the other objectives in mind, as they do form the heart of, what is in effect, Ontario's health plan. And obviously it would be inappropriate to view one element in total isolation from the rest.

I've now been Minister of Health for about 28 months—

**Mr. Conway:** You are telling us on a month-by-month basis.

**Hon. Mr. Timbrell:** It was obvious to me when I joined the ministry that at that time the process of changing the traditional emphasis on active treatment in inpatient care was already well in hand. In fact, as early as January 1973, Dr. Potter, who was then the minister, was saying in his speeches, and I quote: "We have to look for alternatives to active-treatment beds for those who can be cared for equally well in less costly surroundings." Later that year, his deputy minister, Mr. Martin, spoke to the OMA and referred to the necessity of substituting ambulatory for acute general hospital care whenever that was possible.

[4:00]

In his remarks to the Canadian Medical Association annual meeting in June 1974, the Premier (Mr. Davis) referred to the introduction of alternative care and of extended care as programs designed to provide health care to thousands of patients either in their own

homes or in government licensed nursing homes at much less expense than hospital treatment would involve and with equal or even better care.

In 1975, Frank Miller, who was then Minister of Health, said, and I quote: "Some compulsory limit to the number of hospital beds will have to be introduced . . . and by the provincial government or, in some areas, at the local level, by the district health councils." He followed this remark with a call for making more use of alternative-care programs when available, such as home care and extended care.

When I became Minister of Health, I resolved to continue this process.

Mr. Chairman, today this committee is embarking on an examination of a policy direction which has been in effect for some considerable number of years. Therefore, I think I should take this opportunity to briefly explain the rationale behind the policy.

As our society evolved in the post-war years, we placed ever-increasing emphasis on hospitals as the answer to our health-care needs. Health-care workers and patients alike came to rely heavily on institutional solutions to health problems. And institutional solutions, involving as they do complex physical plants, high-cost technologies and expensive manpower, are not necessarily the best means of solving the majority of health problems. Nor, for that matter, are they the most cost-efficient:

The role of general hospitals should be to provide short-term treatment of acute illnesses and injuries. In this role, our hospitals are irreplaceable, and in Ontario, they perform extraordinarily well. They are, however, an exceedingly costly and, indeed, wasteful means of dealing with many health problems. Chronic degenerative diseases, for example, do not always respond to, nor do they require, the kinds of technical therapy and expertise provided by acute-care hospitals.

In addition, the pattern of illness within our society is changing. Our aging population is now succumbing to degenerative diseases which are usually not curable. And yet these cases often end up in hospitals. It makes no sense to spend continuously more on expensive technology in the expectation that it will lead to improvements in public health. The biggest rewards lie elsewhere and I refer you here to the ministry's other objectives of increased emphasis on disease prevention and community health and on encouraging increased personal responsibility for health.

The historic orientation towards active-treatment inpatient hospital care has conditioned health providers and consumers to the notion that the acute hospital setting is the best place to receive all types of care. Undue emphasis on acute treatment care tends to militate against the development of more appropriate alternative forms of care, such as comprehensive chronic hospital programs and home-care programs, which offer important psychological social advantages for patients.

In summary, this policy of de-emphasizing active-treatment inpatient care and increasing the provision of alternatives is founded upon therapeutic and economic grounds. It holds a promise of providing both more appropriate and less costly care.

**Mr. McClellan:** And the emperor has no clothes.

**Hon. Mr. Timbrell:** I'm not sure that you can see, either.

**Mr. Cassidy:** This is Stalinist revisionism, you know.

**Hon. Mr. Timbrell:** Mr. Chairman, I know it's sometimes painful for the honourable member to look at the facts, but—

**Mr. McClellan:** We're looking at the rhetoric.

**Hon. Mr. Timbrell:** Let's carry on, and we'll give you more of the facts and—

Interjections.

**Mr. Chairman:** Order.

**Hon. Mr. Timbrell:** Mr. Chairman, the committee will be aware that prior to 1972, the hospital system in this province was being planned on the basis of a guideline of five active treatment beds per thousand referral population in southern Ontario, and 5.5 in northern Ontario.

With the introduction of the extended-care program, it was seen to be appropriate to amend this guideline. Accordingly, in 1972, the bed planning guideline was reduced to four in the south, and 4.5 in the north. Since that time, all new or expanded facilities have been planned to these guidelines. And of course, this has meant a gradual introduction of change.

Today I think it is clear from our experience that Ontario as a whole is very close to having the right number of beds overall. What is required, however, is a redistribution of beds to achieve a balance in the mix of beds available so that future needs will be met. It was for that reason that we saw the need, as a planning tool, to advise hospitals in February 1978 of the 3.5 thousand referral population active-

treatment bed planning guideline in southern Ontario, and four per thousand in northern Ontario. Most important, I set the old figures for chronic and extended care as minimum guidelines from that point forward.

If the committee wishes later, members of my staff will be available to discuss applications of the guidelines. I hope there is time today for them to take you through this extensive information. I think it would be helpful to the committee.

In January 1979 I also said that my ministry would consider adding more chronic beds where they are shown to be needed. That, in fact, is what is happening in many communities throughout Ontario today. A process of converting active-treatment beds to meet health needs, as identified by health professionals and district health councils, is actively being pursued across the province.

Over the year, the ministry—

**Mr. Cassidy:** This glosses over the ceiling that was imposed on January 19.

**Hon. Mr. Timbrell:** Mr. Chairman, I am not glossing over anything. I don't operate that way.

It's unfortunate the honourable member hasn't shown more interest in this matter over the years or perhaps he would be more familiar with what I am telling him today. But if you just bear with us, we'll be glad to take you through it.

**Mr. Cassidy:** It still glosses over the ceiling that was imposed January 19.

**Mr. Chairman:** Order.

**Hon. Mr. Timbrell:** Over the years the ministry, various hospitals, and district health councils have conducted accommodation surveys to assess the appropriateness of the existing mix of beds by level of care as compared with the needs of the local community. These surveys have demonstrated that in excess of 10 per cent of patients in active-treatment beds should be in some other lesser form of care, including chronic or extended care. I was interested to learn in recent meetings with health professionals in Hamilton and in Toronto that the figure of around 10 per cent appeared to reflect the actual experience in these cities at the present time.

Problems arise when patients who do not require active treatment are, in effect, backed up into active-treatment beds. This indicates there is a need to ensure the appropriate level of care for patients who are now being admitted to hospital. That is why we are pursuing the conversion of active-treatment beds, so as to provide chronic-care facilities



in many communities where they do not presently exist. Apart from ensuring that patients are treated in a setting best suited to their needs, this conversion program has a direct economic benefit since it is more sensible to encourage the appropriate use of existing resources which have already been paid for and which, in many cases, are already funded for operating costs rather than simply adding on additional facilities and programs.

I would not wish to mislead the committee by leaving an impression this simply implies a paper change. For example, it does not mean that a label on the bed changes from active to chronic. A chronic-care program must be developed by the hospital and proposals must be reviewed by the district health councils—Mr. Chairman, I think this is something too important to be treated as a laughing matter by members of the opposition.

**Mr. McClellan:** If there was music this would be a musical comedy.

**Mr. Breaugh:** Point of order.

**Mr. McClellan:** This is ridiculous.

**Mr. Chairman:** A point of order, Mr. Breaugh? What's out of order?

Interjections.

**Mr. Chairman:** Order.

**Mr. Breaugh:** The minister is going to stay for questions after we listen to this, isn't he?

**Mr. Chairman:** I understand the minister has to leave for an appointment.

**Mr. Breaugh:** Might I just register this then, Mr. Chairman. I don't mind if the minister wishes to come in here and read this for an hour, that's fine. I don't even mind the little remarks he throws in—it's a little sad in spots, but that's okay. But if he hasn't got the guts to stay and answer some questions afterwards, I rather take exception to the remarks that he interjects into his notable reading program.

**Hon. Mr. Timbrell:** Mr. Chairman, the honourable member was late today so he didn't hear the earlier exchange. I had indicated to the chairman last week that I had a commitment to meet with the Association of Boards of Health of Ontario in Timmins this evening. In fact, I delayed my departure by some time in order to be able to be here. The alternative was to ask the chairman if we could start tomorrow, and I know you are concerned, as are the other members of the committee, that no time be lost.

What I had proposed to the chairman, with which he had agreed, was that I would make my statement today and Dr. Dyer would take the committee through additional information on budget formulae and various planning formulae and certainly be available in the future to answer any questions.

The member will understand that in the last five or six weeks I have had to put off a great many citizens of Ontario, rescheduling their appointments, and I am trying to meet those commitments as well as my commitments to this committee. I asked the chairman for his understanding, and he has been very good in giving it.

**Mr. Breaugh:** We then, of course, would be prepared to entertain the notion that at some time in the future the minister would be prepared to come to the committee where we might retain the right to ask questions.

**Mr. Chairman:** Yes, I think that was understood.

**Hon. Mr. Timbrell:** By all means.

**Mr. Breaugh:** It would be nice to have that said.

**Hon. Mr. Timbrell:** Mr. Chairman, to start again on that paragraph, I would not wish to mislead the committee by leaving an impression that it simply implies a paper change. For example, it does not mean that a label on the bed changes from active to chronic. A chronic-care program must be developed by the hospital and proposals must be reviewed by the district health councils, or other local planning agencies, to ensure appropriate local input into the process. This is an essential component of the planning process in converting resources to meet changing needs.

Conversion to chronic care is however only one of the many alternatives to active-treatment care. Let me give you examples of other developments in the area of alternatives.

Many of you will be aware of the program of home dialysis, including services in Hamilton, Kingston, London, Ottawa, St. Catharines, Sudbury, Toronto, and Windsor. And this program allows patients to be dialysed in their own homes rather than in an institution. With appropriate supervision there appears to be equal benefit to the patient and the cost is \$9,000 annually, rather than \$22,000 annually if the patient had to be admitted to hospital. At the same time of course this helps to free up beds for those patients who do need to be in hospital.

We are also encouraging hospitals to follow the successful lead of hospitals such as St. Peter's in Hamilton, St. Mary's of



the Lake of Kingston, Oshawa General, Toronto Sunnybrook, South Waterloo Memorial, St. Joseph's in Thunder Bay, Brantford General, Parkwood in London, Queensway-Carleton in Ottawa, and Queen Elizabeth Hospital in Toronto which have all introduced very successful day hospital programs.

The day hospital is a structured, therapeutic day program for ambulatory patients. It helps to avoid inappropriate institutional care, and is designed for those patients who are about to be discharged from a long-term care facility, or who are trying to manage at home.

Similarly we are encouraging the expansion of day-care surgery programs. There is evidence that the pressure for more inpatient services is reduced through the provision of day-care surgery. In Ontario nearly one third of all visits to surgical suites were done on an outpatient basis in 1977. This is a significant increase over 1974, when less than 19 per cent was on a day basis. A number of hospitals have been very active in this field. In Oshawa, for example, about 48 per cent of all the visits to surgical suites was on a day-patient basis in 1977.

In summary, the trend towards the lower-cost alternatives to inpatient care for surgical patients is freeing up beds to be used for those patients who must be admitted.

The ministry has also been developing home-care programs. There are two types of home-care programs, one for active and one for chronic. The active home-care program makes available a readily accessible lower cost alternative means of treatment to institutional care. The objective is to provide an alternative to hospitalization and to decrease the length of stay by providing equivalent treatment services, where appropriate, to patients in their place of residence.

The first active home-care program was introduced in Metropolitan Toronto in April 1964, following a pilot scheme which had begun in 1958. Since then a total of 38 active-treatment care programs had been developed in—and I don't want to take the time of the committee to read the list, but it's extensive, as you'll see.

With regard to chronic home care, a total of seven programs are presently in place. The first was introduced in the Hamilton-Wentworth area on October 1, 1975, and programs now exist in Kingston, Frontenac, Lennox-Addington Health Unit, Thunder Bay, Algoma, Peterborough, Ottawa-Carleton, Haliburton, Kawartha and Pine Ridge. Our objective is province-wide expansion of this program as the resources become available.

The ministry has also been encouraging the development of placement co-ordination services. Guidelines were issued recently to district health councils in this regard. The placement co-ordination service identifies accommodation, programs, and services specifically available in a community, and facilitates ready access for patients to the appropriate level of care.

The first of these services was introduced in Hamilton in 1971. A service was introduced in Thunder Bay in 1974, and in Ottawa in 1976. A placement co-ordination service for nursing homes started in Wellington county in 1977-78 and approval has recently been given to the establishment of a placement co-ordination service in Windsor.

In March we wrote to district health councils to request their assistance in developing placement co-ordination services and we expect to receive proposals by the end of this month. Again, our objective is province-wide expansion of this service.

Among the other developments in the hospital system have been a series of amalgamations and sharing of services among hospitals. These include amalgamation of obstetrics, paediatrics, and chronic services. By this means it is possible for hospitals, working co-operatively, to amalgamate services such as obstetrics when two or more hospitals in a community may each have an obstetrics department, possibly with very low occupancy. Often, as a result of the amalgamation it is possible to provide a better quality service through the concentration of skills and experience while freeing up resources for other purposes.

Since 1970, amalgamation of obstetrics has taken place in North Bay, Brockville—and again I won't take the time of the committee to read the entire list, but again it's extensive—and amalgamation of pediatric services in Ottawa, Chatham, Sudbury, Cornwall, Sarnia and is being planned in Windsor.

Mr. McClellan: Brantford.

[4:15]

Hon. Mr. Timbrell: That's coming.

In addition, there have been a number of amalgamations of entire hospitals, including those in Haileybury and New Liskeard, Smiths Falls, Owen Sound, and the Victoria and Westminster Hospitals in London. In all of these cases it has been possible to generate savings from the removal of duplication of services and still provide more appropriate institutional facilities to meet the needs of the patients.

If a community can generate savings from rationalization of services, then the ministry

stands prepared to act on the advice of the district health council with regard to using the savings to assist in the development of other needed programs in the community. In this way, we are trying to make the best possible use of the available resources. I want to stress that point, because it is absolutely essential to gaining a full appreciation of the changes which are taking place in our hospital system.

Following on this theme, Mr. Chairman, we have been encouraging hospitals to engage external management consultants to review their operations. As a result of such reviews, some hospitals have been able to generate savings ranging up to nearly \$1 million a year. Generally it is my understanding that these savings are realized through better work scheduling. Again, my staff is prepared to discuss this matter with you later this afternoon.

I should also emphasize that my ministry was able to provide a grant to the Ontario Hospital Association to allow it to engage a firm of management consultants to develop a cost-effectiveness program of their own. This program, which deals at present with the service department of hospitals but which I understand they intend to expand into the nursing areas as well, provides an inexpensive means of having a review of the operation and the effectiveness of these departments. Already the program has demonstrated that substantial savings are available in the hospitals where the program has been tested. The OHA is now actively promoting the program and I understand it is planning, as I just indicated, an expansion to cover treatment and diagnostic departments. We are, of course, encouraging hospitals to participate.

As many of the committee are aware, I have been meeting with a large number of hospitals in recent months. And I am glad to say that the need to make changes to meet the changing needs of individual communities has been recognized by most hospitals. However, a number of hospitals I have met with have taken the view that more money is the only answer.

My position is that there first should be a review by management consultants, or the OHA cost-effectiveness program, to demonstrate that the funds already provided are being used as effectively as is possible. In every instance, so far, savings have been demonstrated and these are available to the hospital board to assist it in meeting its commitments. Again, my staff will have specifics for you.

In addition to the grant we provided to the Ontario Hospital Association, my ministry

also provided funding to the Canadian College of Health Service Executives to assist it in the development of a productivity improvement program. This program is designed to help administrators in improving productivity and efficiency. Many administrators in this province and in the Ministry of Health have already attended the program.

But, having said all of this, I still recognize that there are problems. No system as large and as complex as the hospital and health-care system in this province can be without problems. The particular difficulties of small hospitals come to mind as an example. We recognize the special needs of the small hospitals. We know there is a limit below which they cannot function effectively as viable institutions. It was for that reason that we provided a cushion of about 10 beds above the guideline for hospitals with fewer than 100 beds for the 1979-80 budgets.

In addition, I have asked the Committee on Hospital Resource Allocation and Budgets—which I announced at the OHA convention in November 1978 and which comprises representatives of the Ontario Hospital Association and the Ontario Council of Administrators of Teaching Hospitals, as well as the ministry—to review this matter and to advise me in this regard for the budgetary process which will be recommended for 1980-81.

**Mr. McClellan:** Could we have a copy of that communication between you and the HRAB?

**Hon. Mr. Timbrell:** It was conveyed by Mr. Bain.

**Mr. McClellan:** Could we have a copy of the communication between the ministry and the Committee on Hospital Resource Allocation and Budgets?

**Hon. Mr. Timbrell:** It was conveyed verbally by Mr. Bain who is the contact with this group made up of OHA, OCATH and the ministry.

**Mr. McClellan:** This ministry commits nothing to paper.

**Hon. Mr. Timbrell:** I also want to announce, Mr. Chairman, that this September 28 there will be a conference of small hospitals in the province, and at this conference I expect there will be a thorough examination of the budget and bed concerns of the smaller community hospitals, and, indeed, a thorough examination of the role of these facilities during this period of evolution.



One thing must be made clear and that is my determination to maintain viability of these institutions.

**Mr. McClellan:** It's not evident.

**Hon. Mr. Timbrell:** I anticipate concrete suggestions—well, Mr. Chairman, I wish the honourable member could have been with me, for instance, in Nipigon on Thursday where we had an excellent meeting with five of the small hospitals on addressing their concerns and plotting a course of action that will address those concerns and confirm their role for the future.

**Mr. Breagh:** You should have been with me in Smooth Rock Falls because the language used there was certainly unparliamentary.

**Hon. Mr. Timbrell:** Yes. By the honourable member or by somebody else?

**Mr. Breagh:** I always use parliamentary language.

**Hon. Mr. Timbrell:** Yes, I know.

**Mr. Cassidy:** Did you promise to give those hospitals 5.3 per cent, which has been broken in a number of cases?

**Hon. Mr. Timbrell:** One thing, Mr. Chairman, must be made clear and that is my determination to maintain the viability of these institutions. I anticipate concrete suggestions on these topics to flow from the conference—

**Mr. Cassidy:** Say it again.

**Hon. Mr. Timbrell:** —and this information I hope will complement the work of the Committee on Hospital Resource Allocation and Budgets.

I am sure that members of the committee realize that a process of change takes time and must be managed within available resources. It is never an easy process, but I believe that the hospital system is now responding in a creative and realistic way to changing requirements.

All over the province, in places such as Timmins, Brantford, Cornwall, Sault Ste. Marie, Toronto, Guelph and many more, district health councils and hospitals are working on positive changes to meet the needs of the people in their communities for the 1980s and beyond.

In doing so, they recognize that the institutionally based model, particularly the heavy emphasis on active-treatment care, may have been suitable in the 1950s and 1960s but requires modification to meet the needs of the 1980s and 1990s.

Through this period of transition we must ensure the high quality of care provided in Ontario is maintained and, indeed, improved

upon whenever possible. This is, as it were, the bottom line for all of us in the health field and it is very much in the forefront of my mind as Minister of Health.

The process of change which was embarked upon some years ago has reached a particularly crucial juncture. We are making progress, and of that I am convinced. But at the same time there are bound to be difficulties. And therefore it is incumbent on my ministry to remain flexible, approachable and above all sensitive to the health needs of each individual community. No policy can be designed without a recognition that there will always be a need for adaptation and accommodations.

In closing, Mr. Chairman, I would draw the committee's attention to the conclusion of the report of last year's select committee on health-care costs which said, and I quote: "In summary, the committee believes that the role of the hospital in today's changing circumstances must be reassessed. As the emphasis on health care shifts from institutional settings to community programs, hospitals should be encouraged to participate in the initiation and maintenance of these programs.

"The very large cost of hospital care makes it imperative that the facilities are used to maximum efficiency. New approaches involving an expansion of day surgery, home care and other related programs, should be encouraged so as to reserve costly hospital beds for those cases in which medical judgement determines that the need justifies the high costs."

That is precisely what has been happening in Ontario for some time and is in essence the first of the four objectives which my ministry continues to pursue today.

Before I leave, Mr. Chairman, I wanted to draw to your attention an article I saw on the weekend and which I commend to the members' interest. That is the article in the most recent edition of Time magazine regarding medical costs in the United States. You can't help but read this report on health costs in the United States without coming away somewhat depressed. Really, I suppose it wouldn't come as any great surprise to anybody who has been following the debate in that country or the various proposals being advanced by Senator Kennedy, the President and I think 20 other members of the Congress. It's interesting that there are—I think it's correct—presently 21 different bills before the Congress, each purporting to present the way to control the tremendous escalation in health costs in that country.



I also want to commend to the committee, for those who haven't read it—it's probably been read by the Health critics—the McKinsey and Company report prepared for the Department of Health, Education and Welfare of the United States.

**Mr. McClellan:** McKinsey? You've got to be kidding? You wouldn't listen to them on Lakeshore.

**Hon. Mr. Timbrell:** Well, they are a world-wide organization. They prepared a report for Health, Education and Welfare that commended to the attention of the government of the United States the planning processes of Ontario as a model they should follow in trying to get a handle on what, to date, has been an unmanageable problem in that country.

I am going to send copies of the Time article to members of the committee and I have asked for some extra copies of the McKinsey report to send you as well. Mr. Chairman, Dr. Dyer will now carry on with the latter part of our presentation on the various elements and aspects of hospital planning in the province.

**Mr. Cassidy:** Mr. Chairman, before the minister leaves, I have two specific questions which I think he can answer and which would be helpful right now. One is that in response to Mr. Breagh's written question back in March, we have been given the figures of the 1979-80 bed allocation population formulas but not for the two subsequent years. Will the minister now undertake that those figures of the referral population that have been used by the ministry and which were communicated to hospitals back in January be made available to the committee tomorrow so that we can have an indication of the exact number of beds which are to be cut in each major area for each hospital across the province?

**Hon. Mr. Timbrell:** I think in my answer I indicated that that was not possible. I think once Dr. Dyer takes you through his presentation you will see the scope of what I have described in this question of inappropriate use of active-treatment beds and the challenge which is facing us in the redistribution of beds to more appropriate types of units.

I want to just bring to your attention one example that comes to mind, and it may be from one of the hospitals whose representatives will be coming to talk to you. It's a hospital of roughly 100 beds. They've had an 18-bed chronic unit for years; it's been identified that they do have a surplus situation as far as active-treatment beds are concerned. But, when we got around to talking

about converting some of the active-treatment beds to chronic, we found out that they didn't have a chronic program for the 18 beds they have already got, and that had been going on for a number of years. In that particular case, when all the dust has settled, I anticipate we will not only have a larger chronic program to take account of the fact that there is an ongoing need for more chronic beds than is presently being provided, but, there will actually be a chronic program in that hospital, which there should have been all these years but hasn't.

**Mr. Cassidy:** I'm afraid that doesn't answer the question, which is that in January the minister communicated with hospitals across the province and told each one of them what their referral population would be, not just for the current fiscal year but also for the two following years.

**Hon. Mr. Timbrell:** We didn't tell them referral populations for the two following years.

**Mr. Cassidy:** Then you must have given some indication of the number. In that case then there must be some other figures that were given to those particular hospitals in order to give them an indication of the approximate size of the bed cuts they will be required to make in the two following years.

**Hon. Mr. Timbrell:** Mr. Chairman, as I indicated in my written answer, given what we have been finding this year about the possibilities for conversions and the assessments of bed utilization which have been carried out and drawn to our attention, that wasn't possible.

**Mr. Cassidy:** I understand that you can communicate with the hospitals—

**Hon. Mr. Timbrell:** It's a simple matter of extrapolation that if a hospital centre is at four beds per thousand, you can figure out very easily whether they were at 375 this year or 35 or whatever; it's a simple matter of extrapolation. You can do that.

**Mr. McClellan:** On what population?

**Mr. Cassidy:** On what population?

**Hon. Mr. Timbrell:** We only have one year's population at a time. We don't know what the population figures will be for 1980 yet. We haven't got them from the Treasury; we won't get them until September or October.

**Mr. Cassidy:** Perhaps the minister can put it this way then. We estimate that in addition to the 890 active-treatment beds

that are to be cut across Ontario in 1979, as announced by the ministry, there are a further 3,714 beds which will be cut across the province because of the elimination of the 10-bed cushion and because of the further cuts to take place in the two following years. That would raise it to a total of 4,600 beds. Is that an accurate figure or will the minister say exactly how many active-treatment beds in the ministry's estimates are to be cut?

**Hon. Mr. Timbrell:** I would anticipate that by the end of this year the number of beds in the province will be not far off the number of beds we started the year with, in that there will be conversions of beds from active to chronic. There are chronic beds opening in some areas, for instance, in August the West Park Lodge opens, and that will have 500-and-some beds. This is an increase of 200 or so over the older building—the rebuilt Queen Elizabeth, and so on. But, by the end of the year I don't anticipate there will be much difference in the number of beds available. Again, this is part and parcel of answers I have given you before in the House, and what Dr. Dyer is going to take you through today.

[4:30]

Looking into the future, you would say X thousands or hundreds of beds will be cut. I anticipate the need to convert X hundreds or thousands of beds in the province from active treatment to chronic care. If a person has a chronic ailment or a chronic disease and they are presently being accommodated in an active-treatment unit or an active-treatment hospital, then that's not appropriate. Their needs are not, in fact, being met appropriately and they would be better served if existing chronic units were expanded or new chronic units were built or developed by conversion. The first approach has to look at conversions before we start adding.

**Mr. Cassidy:** But how many chronic beds are intended to be added over the next two years and what is the precise number or what is the number of—

**Hon. Mr. Timbrell:** Dr. Dyer will be covering all of this in his presentation.

**Mr. Cassidy:** How many active-treatment beds are to be cut over the next three years?

**Hon. Mr. Timbrell:** Dr. Dyer will be covering all this in his presentation, and I think—

**Mr. Cassidy:** Why can't the minister answer the question?

**Hon. Mr. Timbrell:** Well, I think you should put it in the proper sequence and context and Dr. Dyer will answer it for you.

**Mr. Cassidy:** We have been looking for some overall figures from the ministry and we have a consistent pattern of delays of information and inadequate information. Now, surely as minister, you know how many of the 35,000 active-treatment beds across Ontario are to be cut over the next three years in this program.

**Hon. Mr. Timbrell:** How many are to be converted?

**Mr. Cassidy:** And how many are to be converted?

**Hon. Mr. Timbrell:** Mr. Chairman, as I said, I think Dr. Dyer's presentation which takes the member and the committee through all of the steps will put that into its proper context.

**Mr. Cassidy:** We have to say that the minister knows but won't say.

**Hon. Mr. Timbrell:** You are a joke at times, really.

**Mr. Cassidy:** I am sorry, but that's exactly what's happened.

**Hon. Mr. Timbrell:** No, I am saying that I think the proper presentation should be given to you so everything is put into its proper sequence and context. I anticipate, as I indicated in the House on several occasions, that the need to convert will be considerable. Just as, for instance, in Ottawa, we are rebuilding the Ottawa General. The Ottawa Health Sciences General Hospital will be—what?—50 to 100 beds smaller than the existing Ottawa General, I think. But the existing Ottawa General will be converted from active treatment to chronic care once the new General opens, initially for 150 chronic beds and eventually for 200 chronic beds.

The rationalization in Windsor is while a number of active-treatment beds are being reduced—or cut, if that fits your purposes—an almost equal number of chronic beds will be opened up in the community. What's more, the health council there is looking at the longer-term needs for chronic beds and extended-care beds, and that number will be increased further. So that's what the next presentation will cover. I'd like Dr. Dyer to start.

**Mr. Cassidy:** These conversions cover only this year and do not cover the 3,700 beds—

**Hon. Mr. Timbrell:** They cover the long-term future.



**Mr. Cassidy:** The other question that I wished to ask was—

**Mr. Conway:** A supplementary on your first, and I don't want to keep the minister unduly, but I presume that 100-bed hospital example you cited, without a plan of chronic-care treatment, does not meet the ministry's approval.

**Hon. Mr. Timbrell:** No.

**Mr. Conway:** How long did that exist without your knowing?

**Hon. Mr. Timbrell:** It has existed for the last number of years, particularly since the ministry went to global budgeting to give individual hospitals more discretion in allocating their resources. Now if the ministry were back in 1968, which was the last year of line-by-line budgeting, that sort of thing wouldn't likely have occurred.

**Mr. Conway:** It seems to me your example has indeed encouraged this committee, or perhaps should encourage this committee, to find out how many other such institutions are functioning in a way clearly unacceptable to you, since your own monitoring processes are grossly deficient, if we are to believe that one example.

**Hon. Mr. Timbrell:** As I said to this committee a number of times before, the existence of the community hospital and the community hospital board is both the strength and weakness of the health-care system. It's a strength in that local people add local flavour and input in determining the priorities of that hospital. It's a weakness in that, of course, the ministry cannot dictate how the hospital will function down to the last penny and the last bit of the section of bylaws.

**Mr. Conway:** Just so I understand you, we had a general hospital in Ontario that had an allocation for chronic-care beds within its framework and it had been—

**Hon. Mr. Timbrell:** Which were being filled by chronic patients, but for which—

**Mr. Conway:** For which there was no chronic-care program.

**Hon. Mr. Timbrell:** —there was not an adequate chronic program.

**Mr. Conway:** And presumably an adequate chronic-care program is or should be, a first-order prerequisite for the transfer of funds to keep that particular unit functioning, am I correct? And if you knew about it—

**Hon. Mr. Timbrell:** If you go back to the history of hospital budgeting, until 1968 we had line-by-line budgeting. Since then,

of course, hospitals, being given the autonomy and authority to set their own priorities, have been on global budgeting.

We indicated to the hospital that in our view they had not been giving sufficient priority to the development of a proper chronic program. There was a chronic program as such, the chronic unit as such, but in our view it was not a proper chronic—

**Mr. Conway:** How did you find out about it?

**Hon. Mr. Timbrell:** In discussing with them the conversion of active-treatment beds to chronic-care beds.

**Mr. Chairman:** Mr. Cassidy, you had one more question and I presume the minister has to leave.

**Mr. Cassidy:** I did have one other question. On January 19 the minister said that hospitals having fewer than 50 active beds, or a budget of less than \$1,825,000, would receive an increase of 5.3 per cent because their small size affords less flexibility to meet the financial challenges as in the case for larger facilities.

I don't want to read them into the record here, but there are at least 24 hospitals by our count—

**Hon. Mr. Timbrell:** Eighteen.

**Mr. Cassidy:** —half of them in the south and half of them in the north, which are in fact in that small hospital category but are getting increases of less than five per cent. In the case of the northern hospitals in particular, a substantial number are getting an increase of nothing at all. Why has the minister gone back on that promise made on January 19?

**Hon. Mr. Timbrell:** Mr. Chairman, I did not go back on the promise. If the member wants, I will read into the record, or have someone read into the record for me, the full 17 pages of that statement which the honourable member—

**Mr. Breaugh:** Could we go for an answer instead of a statement?

**Hon. Mr. Timbrell:** Well, very simply, Mr. Chairman, the honourable member has taken one thing out of context.

**Mr. Breaugh:** We've also given you the chance to put another thing in.

**Hon. Mr. Timbrell:** We had indicated in the application of the bed guideline that there would be still, even with the 10-bed cushion and even with 5.3 per cent on the various bases, some that would actually have reductions. If we'd applied the formula exactly as it was written, there would have been hospitals with reductions in budgets.



They were all brought up to a level where they got no less than what they received in 1978-79. That is also in the statement.

**Mr. Cassidy:** So despite the words which seem to be quite clear, the minister is saying that that isn't true at all. That is the starting point before the reduction.

**Hon. Mr. Timbrell:** Mr. Chairman, the honourable member wasn't at the meeting on January 19, some of his staff were. The people who were there from the hospitals heard both parts of the statement just as clearly. I don't think they had any difficulty understanding the statement.

**Mr. Chairman:** Dr. Dyer, you have a presentation, I believe.

**Mr. McClellan:** Just one point to clear up the question about the Committee on Hospital Resource Allocation and Budgets. What is the date on which the communication between the ministry and that committee took place with respect to reviewing the guidelines? What was the date of the communication?

**Mr. Chairman:** Mr. Bain?

**Mr. Bain:** Yes, certainly, Mr. Chairman. The committee met today for the first time this month and this was conveyed to the committee today.

**Mr. McClellan:** Today?

**Mr. Bain:** Yes.

**Mr. McClellan:** At least it wasn't tomorrow.

**Mr. Chairman:** Thank you. Dr. Dyer?

**Dr. Dyer:** Mr. Chairman, the minister has asked me to expand on some of the points he's raised. First of all, I want to deal with the planning process that's been incorporated and has been emphasized in the trends we've had in Ontario for the last few years so we can build up to how we arrive at this year's planning processes.

I want to tell you that over the years there have been two basic kinds of planning processes. One has been a vertical planning process, or competitive planning process, that most hospitals have used. Now we're trying to get into the area called horizontal or co-operative planning. I want to say a little bit more about the vertical and the co-operative and horizontal planning.

**Mr. Conway:** Is there any text for Dr. Dyer's notes, or is it—

**Dr. Dyer:** It's a series of notes I've made. They're not very good.

**Mr. Chairman:** The answer to that is no.

**Mrs. Campbell:** They're not very good. Is that what you're saying?

**Mr. Breaugh:** The answer to that is yes, and that's how he's starting off.

**Mr. Chairman:** Continue, Dr. Dyer.

**Mr. McClellan:** With respect, Dr. Dyer, it presents an insuperable difficulty to the members of this committee to be able to deal with a comprehensive overview in the absence of any text. It really is difficult, Dr. Dyer.

**Dr. Dyer:** I'll be glad to give you any parts of it or we can have it translated for you.

**Mr. Chairman:** Well, I would presume that Dr. Dyer's presentation will take us fairly close to six o'clock and perhaps tomorrow we can run off enough copies for the members of the committee.

**Mr. Breaugh:** Mr. Chairman, you just said that Dr. Dyer's presentation will take until six o'clock?

**Mr. Chairman:** I was just looking at the notes.

**Dr. Dyer:** If we're going through all the steps it could take that long.

**Mr. Breaugh:** I want to point out to the committee that we're supposed to be conducting some form of investigation and in the first day of these hearings there's been no opportunity. It now appears to be an unlikely opportunity for members of the committee to question in any sense, either the minister himself or Dr. Dyer. I find that a rather strange set of circumstances.

**Dr. Dyer:** I think it's fair to ask questions at any point through the address I'm giving you.

**Mr. Breaugh:** I think it would have been fair to have a formal presentation tabled with the committee, and let us ask questions off that.

**Mr. Chairman:** Dr. Dyer does not have a prepared—

**Dr. Dyer:** I don't have a prepared text.

**Mr. Chairman:** —does not have a prepared text apparently and so—

**Mrs. Campbell:** This is the planning process we're talking about.

**Mr. Chairman:** With respect, if we let Dr. Dyer continue, then at any point if you wish to stop and inquire of Dr. Dyer or Mr. Bain, I think that would be quite appropriate and acceptable. That's the only other way that I can—

**Mr. Breaugh:** Okay, let me start there. The minister has just stated that for the last 11

years he's had no effective means of cost control. Do you agree with that statement?

**Dr. Dyer:** No, I don't.

**Mr. Breagh:** Then why did you let the minister sit beside you and make that statement?

**Dr. Dyer:** I didn't think he said there was no cost control because I think they have an effective process—

**Mr. Breagh:** I used the word "effective"—

**Dr. Dyer:** They have effective cost control.

**Mr. Breagh:** —no effective cost control. The minister cited the example himself of a chronic-care situation; 100 beds with no chronic-care program. He softened that subsequently to say no adequate chronic-care program.

That strikes me as a clear admission that you didn't have any cost control or effective cost control as to how these funds were spent. Isn't that about as close as you can get?

**Dr. Dyer:** We had control over the costs in that hospital, but what we're saying is that costs were not defined by a formalized chronic-care program.

**Mr. Breagh:** You didn't know how the money was being spent. And you wouldn't have found out until you sat down with that hospital to discuss conversion programs. This has been going on for 11 years.

**Dr. Dyer:** In the global processing mechanism of funding, the hospitals are awarded a global budget. Every year that's inflated by whatever the factor is we have available. As a result of that, they spend the funds within the globe as they see fit. Now they do so in accordance with approved allocations.

There was an allocation of 18 chronic beds for that hospital. They were used for chronic patients, there was no doubt about that. That hospital was operating chronic care. What we're saying is they had no standardized chronic-care program, as we'd recognize it. We'd like to see that developed across the province.

**Mr. Breagh:** The minister cited that and you sat beside him and listened to him say it. It was one example quoted by the minister himself, that you did not know how the money was being spent. Well, is that effective cost control or not?

**Dr. Dyer:** Cost control and the definition of the health care in that sense are two different things. The cost control was in terms of their global budget and how much they were allocated and that was reviewed. That's reviewed by a budgeting process and audited. That's the cost control.

**Mr. Breagh:** How can you say that when the minister sat there and said he didn't know it was being spent in that way?

**Dr. Dyer:** We knew it was being spent for chronic patients in 18 beds.

**Mr. Breagh:** Well, he said it was for 100 beds.

**Dr. Dyer:** No, for 18.

**Mr. Chairman:** One hundred beds in total, 18 of which were chronic.

**Dr. Dyer:** Eighteen are chronic.

**Mr. Conway:** You seem to know it, Mr. Chairman.

**Mr. Chairman:** I know it very well.

**Mr. Breagh:** I wonder why.

**Mr. Chairman:** I wonder.

**Mrs. Campbell:** Did you at the time this started have any program you could put to a hospital as an appropriate program for chronic care? Or did you pay the money out and just let them do whatever they liked, because you yourselves didn't have a program?

**Dr. Dyer:** Yes, there are defined chronic programs?

**Mrs. Campbell:** Were they at the time this started?

**Dr. Dyer:** Yes. They're defined chronic programs.

The Ontario Hospital Association has an outline of a chronic program and there are various elements required in it. As a matter of fact, they gave something around 18 to 20 beds as a minimum for chronic-care programs. That size is adaptable to that kind of chronic-care program with rehabilitation and occupational, physical therapy plugged into that.

Now we're not saying this hospital did not have those elements, but it wasn't defined in any formal way we could examine. They might have had it, but it's not defined in any way we could examine.

**Mr. Breagh:** Excuse me, Mr. Chairman. I don't understand what's going on here. The minister quotes it as an example of an area where they should have put in more cost control. The staff says it didn't need the cost control. The minister says they used global budgeting and didn't examine how the funds were spent, and Dr. Dyer says they did.

I'm at a loss to know who to believe in this instance. You know the hospital, Mr. Chairman. Why don't you take a shot at it? [4:45]

**Mrs. Campbell:** You tell us about it.

**Mr. Chairman:** Yes, I know the hospital well, but I think we should let Dr. Dyer move along with his statement.

Mr. Riddell, you had a question and I wonder if you could pose the question, then we can move along. Dr. Dyer does have considerable material he wants to put on the record.

Mr. Riddell: I'm not sure where you're at in your deliberations, Mr. Chairman. I was going to ask questions specifically on the Goderich Hospital situation.

Mr. Chairman: Well, perhaps we could leave that for a moment, Mr. Riddell, and proceed with Dr. Dyer's statement.

Mr. Conway: I have a supplementary and it's a supplementary to Mr. McClellan's rather interesting point. I don't think we should pass it over without one further elaboration. This whole business of the new bed ratios and their import on budgets and small hospitals, in particular, has been with us for at least four months and mooted for much longer. It is absolutely fascinating that the minister should come today and make a statement, which is predictable. I suppose, that indicates on page 21 he has asked the Committee on Hospital Resource Allocation and Budgets to look at the problems of small hospitals, et cetera, and then moments after the minister's departure, we're told this committee met this morning for the first time since its creation in November 1978.

Mr. Bain: Mr. Chairman, if I can correct that. I thought I said the committee met for the first time this month. In fact it was the second time this month. It has been meeting every two weeks since, I believe, February or March. It's meeting very regularly, and working very hard.

Mr. Conway: That's the elaboration I wanted. I was left with the impression that the committee had met today, or these past few days, for the first time.

Mr. McClellan: When was the decision taken to hold the conference on small hospitals?

Dr. Dyer: I don't know the exact date, Mr. Chairman, but it was about three weeks ago.

Mr. McClellan: Has the notice gone out?

Dr. Dyer: No, the notice has not gone out to small hospitals yet. We're negotiating that with the Ontario Hospital Association. We met with the Ontario Hospital Association liaison committee, and it was with them we decided to have a joint small hospitals conference. The date was set for some time in September. So the notice has not gone out to the small hospitals.

Mr. Breagh: In effect you're saying you decided to hold this conference for small

hospitals just about the time this committee decided to look at that stuff.

Is that right? About three weeks ago?

Dr. Dyer: About three weeks ago.

Mr. Breagh: And you're probably saying there's no relationship between the two events.

Dr. Dyer: I don't think so; no.

Interjections.

Mr. Chairman: Dr. Dyer.

Dr. Dyer: I want to deal first with the vertical type of planning that's been consistent in hospital operations for many years. That is a type of planning in which the hospital looks to its own individual needs and its own individual wants, and plans within that context. That's why it's called vertical planning, because it's within the four walls.

Vertical planning isn't carried out in co-operation with other hospitals in the community. That type of planning, as we all know, builds ever large hospital operations, and it also creates duplication of services. We believe that it was probably a proper form of planning in earlier years. There are some communities in the world, namely in the United States, where that kind of planning leads to competition in prices. It's appropriate there as well where a hospital may compete with its neighbours and give lower fees to the patients and clients who come to the hospital.

Now, the problem with vertical planning in Ontario is it's inappropriate when done in isolation. There was an era when funding was provided to meet the requests of hospitals. We were funding them during inflation. There was little incentive to do other than vertical planning. As you can see, the more the hospital requested, the larger they built their base and the more money they acquired in terms of the inflationary amount they got the next year.

Mr. Conway: Is it possible ever to have appropriate vertical planning, since it is naturally so narrow?

Dr. Dyer: I don't think it is. It's appropriate only if it's in a context with horizontal planning as well. Of course, some vertical planning and constraint and in-house planning to conserve resources is appropriate.

Mr. Conway: Well, now, just hold on. Are you suggesting that vertical planning and horizontal planning, such as they may be, are not mutually exclusive?

Dr. Dyer: No, they're not.

Mr. Conway: They're not.

Mr. Breagh: That's called diagonal planning.



**Dr. Dyer:** The problem is—and I hate to use the word—vertical planning tends to be competitive, as you well know. You tend to build your enterprise in competition to your neighbour, rather than in co-operation.

**Mr. Conway:** It's what we laymen might call empire building. Is that it, basically?

**Dr. Dyer:** That would be a phrase some people use, yes.

**Mr. Conway:** I caution you not to be too technical or too bureaucratic, because you might lose some of us.

**Dr. Dyer:** I'll try not to. Over the past few years, when global funding was constrained as well, a variant in this vertical planning was also exercised. In fact, the hospitals simply constrained within their operations, as a rule, but generally there was an attempt to preserve the status quo, in order that they preserve their bases.

I'm not saying that applied all over, because there were definite efforts to plan with their neighbours and live within that constraint funding. But many of them were a little hesitant to do so, inasmuch as when they did that, they would lose some of their base. If they amalgamated an emergency service, or a laboratory service or an obstetrical service, then the operation that got that service would build its base, and the operation that gave up the service would tend to reduce its own base. And so, without some kind of incentive that generates horizontal planning or co-operative planning, you tend to get, even in a constraint era—and that's the point I'm trying to make—this kind of vertical, in-house planning.

So what we needed was some kind of positive incentive. The first major thrust for horizontal or co-operative planning was through the creation of the district health councils. And at the same time it was recognized around the world that some planning guidelines were needed to define the appropriate levels of services. Since active-treatment beds contributed the highest-cost item that could be planned and controlled, many jurisdictions adopted guidelines for this particular entity.

As early as 1972, for example, Ontario reduced the guideline on active-treatment beds from five beds per thousand in the south, to four beds per thousand in southern Ontario and 5.5 to 4.5 in the north. At the same time, techniques were developed along with that to indicate the bed allocations for these guidelines that were age weighted, since age weighting and the age of the population is the major variant that affects the utilization.

Now we have given you details, I think, on the bed-allocation methodology, and if you would like an example of that, we can run that through for your edification.

**Mr. Breagh:** Could you just pause there for a moment and elaborate as to how you arrived at you formulas? You mentioned one variant, age. What other variants are involved in establishing that formula? How do you come up with a formula or two formulas that apply province-wide? What's the basis of preparing the formula in the first instance? What are the ingredients that go into making that formula? And, in applying it, how do you get away from two very broad geographical areas?

**Dr. Dyer:** If you're talking about the bed ratio itself, I'll get into how that's established. It's established somewhat empirically, but it's based on actual studies.

**Mr. Breagh:** Which actual studies?

**Dr. Dyer:** Accommodation studies.

**Mr. Breagh:** Done by whom?

**Dr. Dyer:** They're done by the district health councils, hospitals and the Ministry of Health.

**Mr. Breagh:** And you have those and you're prepared to table them here in the committee?

**Dr. Dyer:** I haven't got the studies here, but there are studies that can be made available if you want.

**Mr. Breagh:** And prior to your striking this formula, that's how you came about the formula? They all came up with the same, identical formulas?

**Dr. Dyer:** No, don't misunderstand me. The bed ratio prior to 1972 was five beds per thousand. In 1972, that was reduced to four beds per thousand.

**Mr. Breagh:** Why?

**Dr. Dyer:** At that time, there was an expansion in extended-care facilities. We'd built something like 9,800 extended-care beds, and the concept of adding on at that time was that that would reduce the load on active-treatment care.

**Mr. Breagh:** And the study shows that direct relationship is what?

**Dr. Dyer:** There isn't a study that shows the direct relationship at that time. But, if you add that number of beds—

**Mr. Breagh:** Just let me pause there. Prior to making this change in the bed-ratio formula, you thought you had the numbers, but you didn't have any direct relationship established. Is that right?

**Dr. Dyer:** That's right. There's no direct relationship, because obviously what we're talking about is relieving the pressures on active-treatment beds. Around the world, the concept at that time was recognized that there was a need for guidelines in active-treatment beds. Many jurisdictions adopted guidelines. The four beds per thousand guideline is no different from that in many areas around the world—as a matter of fact, the 3.5 is no different. We can give you statistics and so on, showing the other provinces as well as other jurisdictions, and the kind of active-treatment bed guidelines and long-term care guidelines they have adopted as well.

**Mr. Breagh:** But surely you're not making an argument that other jurisdictions in the world—so different geographically from Ontario—have guidelines which are even rational in this province.

**Dr. Dyer:** For example, the active-treatment bed guideline in Quebec, which is essentially no different from Ontario in that regard, is 3.2 beds per thousand at this time.

**Mr. Conway:** What is it? Three point two?

**Dr. Dyer:** Three point two, yes. Now, at the same time, they have a different guideline for long-term care needs. That's the kind of shift. We'll try to explain to you how we see this shift.

**Mr. Breagh:** Okay, but where is the study? Where are the numbers which show that you've gone from something you thought was wrong to something you know is right?

**Dr. Dyer:** No, I don't think we say we thought that five was wrong or that four is necessarily right. We were saying that we were changing an active-treatment guideline; at the same time we were adding a large number of extended-care facilities. The concept of adding those on—and it's still thought to be true—is that when we can expand the chronic and long-term care facilities, we relieve the pressure on the active-treatment bed component. The concept is not in applying a guideline, but moving towards it.

Now, when the four beds per thousand was applied, the actual number of active-treatment beds was about that. It was applied as a planning guideline. There was no forced reduction to that level, by any means. It was applied as a planning guideline; there was no reduction to four beds per thousand.

**Mr. Breagh:** And when was this?

**Dr. Dyer:** That was in 1972.

**Mr. Breagh:** There wasn't any reduction eh?

**Dr. Dyer:** No. There was no forced reduction to that guideline at that time. As a matter of fact, the number of beds per thousand in Ontario right now is still 4.2, so we're still above the guideline that was set in 1972. And it has come down to that—it has come down from levels that were higher than that. But it's still above the four beds per thousand at the present time.

**Mr. Conway:** What levels were—let us say if it's 4.2 now generally for the province, what's it come down from?

**Dr. Dyer:** In the past couple of years it's come down from 4.8 to 4.2, so that it is moving down. Perhaps the expansion of other services—and we hope this is the case in the planning guideline—that expansion of other services such as extended care, day surgery, day hospitals, is relieving the pressure on active-treatment beds. What I want to show you are the accommodation studies that have been done. These will indicate to you the actual number of active beds in use today. The actual number of active-treatment beds in use today is consistent with the guideline of 3.5 beds per thousand. We have studies that can reflect that. The studies will reflect higher than that in terms of chronic usage of active-treatment beds. We can provide those for you, if you like.

**Mr. Breagh:** Yes, I would very much like to see that, but I just can't let that statement pass without noting that in many places of Ontario, the reality of the hospital is such that what you just said is nonsensical. We can go to Smooth Rock Falls and see the 18 or 17 beds they've got there empty one day and full the next. So the basis upon which you're establishing a guideline is nonsensical in that instance.

[5:00]

**Dr. Dyer:** Well, the average utilization of active treatment beds across the province is about 80 per cent. That's the world health planning guideline, for 80 per cent utilization. Now that's an average throughout the year, and that's what our figures show. Our average utilization of active-treatment beds—the 35,500 beds—is about 80 per cent of the time, on the average. Sometimes it'll be down, and sometimes it'll be packed, as we all know, when we work in hospitals. There will be times when those shifts occur. But on the average, and the daily census data from hospitals indicates it, the utilization is only 80 per cent at this time.

**Mr. Breagh:** Let me stop you right there, because this is interesting. You said that the actual ratio is about 4.2 now, and that your



guidelines of usage is about 80 per cent, which is about right. So would you explain to me why we're into this mess?

**Dr. Dyer:** I'm not sure we're in any mess. What I'm going to try to explain to you—

**Mr. Breagh:** Then why do you go around discussing hospital budgets with cuts in it of this nature?

**Dr. Dyer:** Well, I'm trying—

**Mr. Breagh:** If everything is fine now, why are we moving to a lesser degree?

**Dr. Dyer:** What I'm trying to explain to you is this: when you go from the mode of vertical planning, everybody plans competitively and builds duplicated services. You attach fiscal encouragement to that, as we have this year, and when you try to do that, to get co-operative planning, it's not an easy process. People change from a tendency they've had for years to protect the enterprises they have. When you try to go from that to a co-operative planning mode, you do so by attaching dollars to it—financial incentives—then it's somewhat painful. That doesn't mean to say it's improper.

**Mr. Breagh:** I appreciate what you're saying. You have said on a number of occasions already this afternoon that the vertical planning mode—excuse me for using that term—

**Dr. Dyer:** Use whatever term you like.

**Mr. Breagh:** —has resulted in a number of very bad things. You have yet to mention a specific. You have rather castigated various hospital boards for duplication of services, and you put a few aspersions on empire building, but I haven't heard you give me the one example which proves that what you said is true, and that in fact, we've got to get out of that. Now would you do that for us? Will you tell us which hospital has too much equipment, too many staff, too many beds?

**Dr. Dyer:** I'm going to get into examples a little later if you will, of a town that's not too far from here, Brantford, that is now going through the painful process of changing from vertical planning to co-operative planning. What has happened there is the problem of chronic beds in each of five hospitals. For example, they have duplication of obstetrical services in each of two hospitals, they have duplicate emergency services in each of two hospitals. That community now sees the need to do some kind of co-operative planning to amalgamate and to change over services.

**Mr. Breagh:** I seem to have heard a dissenting opinion on that somewhere.

**Dr. Dyer:** What they're proposing at the first stage looks very interesting. It's not an easy process. It's painful sometimes for medical staff to see a change in the role of an institution that they have built up in competition, quite frankly, to their brethren down the street.

In Windsor, it was the same. In Windsor, they had three obstetrical units, 50 per cent occupied. That means we are maintaining three obstetrical units there at 50 per cent occupancy, far below the planning standard. The planning standard is 70 per cent occupancy. There was no co-operation until we started getting them together with the district health council. They have now come to their own conclusion that they can well get along with two. In fact, they came to the conclusion that they could get along with one, but it was too painful to go that big step. So they've amalgamated into two. One of them will be a far better unit than it was in the past. One will be associated with a neo-natal intensive care unit and will combine within that hospital the right kind of services, better services than you can get spread out.

If you look at some of the communities in the northwest of Ontario, you'll find hospitals that are doing 85 live births a year. You can't maintain the kind of expertise when you do that kind of activity. Even in the United States—that's free enterprise—they strike as a meaningful guideline 1,000 births a year as an appropriate obstetrical unit. So if you want to plan, and you want to get co-operative planning, you've got to come to grips with some of these problems.

**Mr. Breagh:** Which of the hospitals in the northwestern part of the province has that low a rate?

**Mr. Chairman:** Mr. Breagh, I understand your interest and concern, but I see that Dr. Dyer has a lot of pages here and we're only on page three. In view of the time, I wonder if we couldn't allow Dr. Dyer to proceed and hopefully at the end we'll have a chance to review some of these things, provided the statement doesn't respond to the particular questions and concerns that you and others on the committee have at this moment. I'm just concerned that we're not going to get beyond page three at this rate, and I think it would be appropriate to have Dr. Dyer continue.

**Mr. Breagh:** I'm not concerned about getting beyond page three. I am concerned



that people on this committee, like Mr. Riddell, do get a chance to ask some questions and get some answers.

**Mr. Chairman:** I am too, but as chairman I have to be assured that it's done in an orderly fashion, and I think perhaps at this point the best method of procedure would be to continue at least for a while.

**Mr. McClellan:** Why don't we set a limit? I'm tired of the Ministry of Health people coming into this committee and using up the time with their own presentations and then leaving before we have a chance to ask our questions. That was the pattern in the Lakeshore experience, and I'm very much opposed to allowing that pattern to continue. I suggest that Dr. Dyer proceed for about 20 or 25 minutes, and leave us some time to ask some questions.

**Mr. Chairman:** Could we carry on until about 5:40?

**Mr. Breagh:** How about 5:30? That's reasonable.

**Mr. Chairman:** All right, without interruptions.

**Mr. Riddell:** My questions, Mr. Chairman, will further indicate the inconsistencies that exist in the ministry. My understanding is we're getting a different story from the minister than we are now from one of his top officials, and what I will be bringing up will also indicate the same.

**Mr. Chairman:** Perhaps we could carry on with the statement, Dr. Dyer.

**Dr. Dyer:** I don't want to dwell too much longer on how we have to get away from vertical planning into this co-operative planning mode. You should be aware of two major factors that have done that in the past few years. The first one was the creation of district health councils. That at least gave us the mechanism by which we could get local input and a decentralized approach to a kind of co-operative planning, without vested interests involved in it. I'm sure you know that the district health councils are composed of members deliberately chosen so they don't have major vested interests incorporated in that.

**Mrs. Campbell:** Yes, we know.

**Dr. Dyer:** Obviously the district health council is not the only means of getting co-operative planning. There's been co-operative planning going on between health councils. We have a health council in Metropolitan Toronto, the HCMT, and UTHA—Hospital Council of Metropolitan Toronto and University Teaching Hospitals Association—groups that very effectively do co-operative planning.

As a matter of fact, an announcement was made a few days ago, whereby Sunnybrook and the Toronto Western Hospital and Doctors Hospital are getting together to do co-operative planning to see how they can amalgamate and consolidate and rationalize the services in those three units. That's going to be a very important step in Toronto.

As I mentioned, the constrained funding approach we've had over the past years—since about 1976 we have been funding in a fashion that has been somewhat less than inflation—has had a sobering effect on the growth of the institutions, and the effect that's had in terms of conserving resources can't be underestimated. It's an important means of conserving financial resources and also health resources. However, in terms of health-care planning for the future, and in terms of trying to meet the growing needs and the changing needs that kind of planning is not going to be appropriate.

What we need now is the more co-operative approach so we can get across the whole hospital centres a kind of rationalization of services. We need that kind of broad-based planning if we're to achieve those kind of aims. While the district health councils provided us with the mechanism to accomplish this kind of co-operative planning, it was certainly recognized that we needed positive incentives to foster it. District health councils often proposed well-meaning plans that were ignored by the adherents to the empire-build kind of approach to planning.

The budget methodology adopted this year, incidentally, has had a major impact in providing the kind of stimulus we see. We adopted the principle whereby annual increments on budgets were linked to the bed guidelines for the first time for active care, with the added incentives of an increased inflationary amount—I can get into the details of this later, if you want, for chronic care and outpatient care. As a result of that stimulus we really are witnessing quite a remarkable effect across the province in terms of action towards co-operative planning.

Communities such as Windsor, Timmins, Brantford, if you like, are excellent examples, and I'd like to deal with some of those communities. Perhaps we'll see what can be accomplished.

A matter of fact, the commitments in these areas have resulted in signed agreements between hospitals and district health councils we have not seen before. We have never seen signed agreements of commitments to undertake co-operative planning, so it's an interesting approach that's developing.

In Essex county, for example, there was an agreement signed between the district health council and four major hospitals to amalgamate obstetrical services and paediatric services—there are three paediatric services that are now amalgamated into two—as well as a planned reduction and conversion of active-treatment beds to meet chronic-care needs. They have an agreement to proceed along those lines, and in a sense there will be no loss of programs.

In fact, the funds that were identified with the surplus active beds that were phased out in moving toward 3.5 beds per thousand, this year are \$1.3 million in the city of Windsor. Those funds were retained by that community for additional programs. They weren't taken out and put somewhere else if they, when rationalizing the services, identified that kind of money, so \$1.3 million is retained by that community to provide new programs.

The new programs that have been identified for funding as a result of that kind of rational approach have been, for example, expansion of a chronic-care unit and chronic-care facilities, to give more usage there; a coronary care unit, that they haven't had; this neo-natal intensive care unit I mentioned to you; a CAT scanner is going into the Hôtel Dieu; and a placement co-ordination service. In a sense those five programs will be funded within the global budgets that were provided, with the normal increments, this year. So in that community we gained five programs for the same kind of dollars that were spent on surplus services that were used there the year before that they have now come to grips with.

That kind of co-operative planning really can't be underestimated. I don't want to make you think that the task of achieving those kinds of objectives and those kinds of changes is an easy one. It's not easy. It is somewhat painful in many areas. It's not going to proceed without some hitches from time to time. It would be naive for us to believe that it will go very smoothly, so we'll have to keep working at it and encouraging them to move along and keep that planning on the rails. If they keep going in that direction they will end up with more programs in their community, and Windsor and Essex will benefit by that.

Timmins, though it's smaller, illustrates a somewhat different perspective in health-care planning which I'd like to use as an illustration. In the community of Timmins and South Porcupine we had identified, more than a year ago, a need for 40 chronic beds and 22 rehabilitation beds. That community

had neither of these kinds of services. As a matter of fact, in terms of rehabilitation, many of their patients working in the mines there have to travel to Toronto for workmen's compensation. They need a rehabilitation program there.

In terms of getting those programs in place, both hospitals—and I'm not faulting them—were in the vertical mode of planning. They did not want to change any of their programs; they wanted to retain their active-treatment care programs. They said: "Fine, we'll accept the programs. Add them on." Before the January 19 process it looked like the only mechanism we'd have to do that would be to add them at the resource centre or build onto either of the hospitals. The operating costs of that alone would have been somewhere between \$1.5 million and \$2 million a year for those 62 added beds.

#### [5:15]

As of January 19 it was identified that there were 29 surplus active beds in that community, and their budgets were constrained: 29 times \$12,000 or \$348,000. As a result of that kind of incentive, the hospitals and the district health council formed a committee to convert, rather than add on, the surplus active beds to partially meet those needs. They now have signed an agreement in the same way that Windsor has to plan towards that. We will be able to meet most of the chronic needs and the rehabilitation needs by the conversion of active-treatment care.

What will happen is the small obstetrical unit—there were two of them—at the Porcupine General will be moved to Timmins to the St. Mary's Hospital where they have a new unit. They'll phase out the one at the Porcupine General, and the Porcupine General will take on the role of a chronic-care hospital, retaining some active care as well. They are now committed to the role of a chronic-care hospital as well. As a matter of fact, they will phase out more surplus active beds than they actually were required to do under the identifiable number, but they will accommodate that kind of service there. In doing it by that means, the saving in operating costs will be \$1 million a year. There is real potential there. Not only is there a \$1 million saving but the remarkable thing about it is that that community now has broken away from this competitive planning mode and is co-operating, and that is going to set the stage for future planning there.

As a matter of fact, one of the interesting parts of it is that the medical staffs of both hospitals have now agreed to form a joint medical advisory committee, a joint admission



and discharge committee. That kind of co-operation was literally unheard of a year ago. They weren't even talking to each other a year ago.

In Brantford, the situation is somewhat different. There we have five hospitals, each with chronic units. That particular community has one of the highest numbers of surplus active beds. If you take the surplus active beds, identified at 3.5, it's something like 122 beds. At the same time, they have a deficit of chronic beds and no rehabilitation program.

They haven't reached the stage of definitive plans. The first plan they submitted for consideration to the ministry was fairly interesting. They are actually looking at it being as forward as phasing out one hospital and converting it entirely to chronic care. That's very encouraging, because if you can get a hospital to convert totally to chronic care, you have the best mixture you can get, instead of five of them operating five units.

In the long run, when they go through that, if they can pull it off—and they have now signed an agreement to work towards it—they will virtually not have had to close active-treatment beds. They'll have practically the same number of beds they have today, but they will be reassembled. Out of that, they will have better programs and an amalgamation of obstetrics, paediatrics, chronic care, and emergency services. In addition to that, there will be a saving—we haven't got it fully identified yet—of somewhere between \$500,000 and \$1 million a year. That community is already asking, as Windsor has, can it identify new programs that it can use those savings on, which is a reasonable planning approach.

I want to turn back to the question you started, Mr. Breugh; that is the question of the bed numbers. I think the minister said it and we have said it around the province recently that we think the total number of beds is about the right number. There are about 80,000 total beds in terms of active, chronic and extended care, of which, at this present time, something in the order of 35,500 are active-treatment beds. I am watching the time, Mr. Chairman.

Accommodation surveys have indicated that anywhere between 12 to 20 per cent of those beds are occupied by patients who are not receiving acute care. We can show you accommodation studies where up to 25 per cent of the beds are occupied by patients who are not receiving acute care. If you take a conservative figure of 12 per cent of 35,000 beds you come up with 4,500 beds in the province that are classified as active-treatment beds but are not being used for active

treatment. If you take that number of 4,500 away from 35,500, you arrive at 31,000 active-treatment beds that are actually in use and available for active-treatment patients. That number of beds is closely approximated to 3.5 per thousand.

I think that's the most cogent defence for the standard of 3.5 beds per thousand. In reality that is the number of active-treatment beds that are being used today for acute care. What we would like to see happen, and what we are encouraging, is the reclassification of the beds of the patients who are in there inappropriately and the development of units to accommodate them more appropriately. It isn't appropriate to have chronic-care and extended-care patients or even home-care patients in active-treatment beds. That just isn't appropriate planning and it isn't an appropriate expenditure of funds.

So what we are trying to do is identify those as surplus beds, if you will; and they are surplus to the need of the acute care, because all we are using today is 31,000 beds for acute care. If we can classify them and have them changed over and chronic-care or extended-care programs attached to them, we will have better and less costly health care in the long run.

In addition to that number of 31,000 active-treatment beds in use today, we know that by 1984, with the changes in age mix, the demography of patients and in aging population, the number of acute-care beds that will be needed will be close to 32,000. That again is what we are estimating to be 3.5 beds per thousand of the population at that time. Of course there will be changes in the bed-allocation methodology according to the mix and age weighting—and all of those factors have been taken into account—so they are very rough estimates. But that's what we are guessing at the present time.

At the present time, in addition to those 35,000 beds, some inappropriately used, there are 9,000 chronic beds in the province. By 1984 the 9,000 chronic beds will fall short of the 11.9 chronic beds per thousand of the aging population over 65 by some 2,000 beds. So we know that by 1984 we may need something in the order of 32,000 active-treatment beds and we will need at least another 2,000 chronic beds to meet the minimum standard. That minimum standard of 11.9, incidentally, is lower than any other chronic-bed standard across the country, so we realize that's a minimum. We don't exactly know what the maximum is and we have studies being done by district health councils and by hospital planning councils to determine the amount or



the extent of chronic-care and extended-care facilities that are needed in their communities.

To start with, those patients in the 4,500 beds that are inappropriately occupied need to be identified. We have some surveys that will identify the kind of patients occupying those beds. That will help us in accommodation surveys to find out just the kind of beds and the kind of accommodations needed for planning in the future.

One of the major impacts in terms of getting hospitals to approach that has been the bed-allocation method, since we deficit-funded or constrained the forms for the surplus active beds. It's now surfacing that the hospitals have started to come back to us and say they have chronic patients in those beds. It was not through any fault of theirs they weren't that ready to identify the chronic patients in active beds before this. It was simply because of the planning mode I talked to you about before, the protective vertical-planning mode that tried to retain most of the resources they could. It's a natural reaction.

Have I got five minutes, Mr. Chairman?

Mr. Chairman: Yes.

Dr. Dyer: In the communities I mentioned, Windsor, Timmins and Brantford, if they develop a plan of conversion of the surplus active beds and a rationalization of services, then the money that's constrained in terms of surplus active beds is reinstated. As a matter of fact, since Timmins has come up with that plan, the \$348,000 that was constrained has been put back in their budgets, and they are now moving ahead with that to accommodate the new services that are needed. We'll end up there, as I mentioned before, with better services.

At this time, the money in Brantford has been identified for them, and when they come up with a rational plan, and I suspect it will be much like the first one they proposed, reinstatement of the funds can be made. Then you're reinstating funds according to a definite need, not according to a surplus need identified on a guideline.

The last part I want to cover only briefly, is with reference to the cost savings that have been taken through management consultants. One of the hospitals you will be seeing tomorrow in your chairman's area was in to see us, along with the other one. In each of these cases when they are requesting funds, we suggest they engage management consultants. I understand one of those 100-bed hospitals has now gone through the initial stage, the survey stage, when management consultants have looked at their operation, and they've identified several hundred

thousand dollar savings a year that can be achieved through proper staffing management in that hospital.

Those savings won't be taken away from the hospital. If the hospital implements those steps, they're not really savings that are removed. Those savings will be used either to meet their deficits or to implement new programs that are necessary.

The amount of money identified there is a substantial sum, but that's been repeated across the province. We have a well-run teaching hospital in southwestern Ontario that went through a similar exercise, and the amount of money identified was \$1 million a year in operating savings.

For another teaching hospital in the Ottawa area, the amount of savings was in the range of \$850,000. These savings have actually been identified and implemented.

There are five hospitals that have currently engaged and employed the consultants, and the amounts of money that have been identified as potential savings in those hospitals range anywhere from \$230,000 to \$930,000, depending on the size. The overall average appears to come out something around \$2,000 per bed when proper staffing methods and proper organization is used within management techniques in those hospitals.

We have not yet found a hospital that has engaged consultants that has not been able to pay not only the consultants' fees, but identify savings they can use for their own programs, or other programs in the process. We're encouraging this. As you will see tomorrow, we also encouraged Wingham to do the same thing, but we don't know what progress they've made in that area.

At the present time there are 25 hospitals throughout the province in the throes of either the initial surveys, or of engaging consultants to implement savings. Incidentally, there are some firms that will go into a hospital and spend two weeks in that hospital and do a general survey. Out of that they will identify what they say is the amount of savings and that savings identification is generally on the low side. That survey, when done by some groups, is free of charge. It doesn't cost the hospital anything to have the survey done, because when the hospital engages the consultant to implement the savings, they pay their fee. The fees, as I mentioned, are always less than the amount of savings that have been identified to date.

[5:30]

The minister mentioned the OHA program. We have at this present time four hospitals—Ross Memorial in Lindsay, Wellesley, Mississauga, and Milton—which have

been participating in that program. Their annual savings range between \$15,000 to \$250,000 a year. Those hospitals have been participating with the OHA only on the service department analysis as the OHA project doesn't involve the diagnostic and treatment areas.

**Mr. Chairman:** How many pages do you have left, Dr. Dyer?

**Dr. Dyer:** That winds up most of the things I want to say on the guidelines. I think we have dealt with the rest in questions anyhow, Mr. Chairman.

**Mr. Breagh:** I want to raise a point of personal privilege. I asked a written question in the House, tabled on March 7. I received this written reply from the minister: "The ministry is not able to determine the number of chronic-care patients who may be occupying active-treatment beds from current information reporting systems." Yet this afternoon the thrust of the entire argument is that they not only can, but they have done. Someone tells me falsehoods. Who?

**Dr. Dyer:** You're misreading that. What was said to you—

**Mr. Breagh:** I read it verbatim. I'm not misreading. Those are the actual printed words. Here it is.

**Dr. Dyer:** What was said to you is that accommodation surveys have identified—and each survey is different — that somewhere between 10 to 20 per cent of the patients in active-treatment beds are not acute-care patients. They're something else. They're patients either receiving chronic care or extended care or they may equally well be treated at home. They're not necessarily all chronic-care patients.

**Mr. Breagh:** I asked a very specific question to which I got a very specific answer. It differs substantially from what you've just said to this committee.

**Dr. Dyer:** Your question was, can we identify across the province? We've taken individual surveys—

**Mr. Breagh:** As a matter of fact, I asked "in Ontario hospitals," offering you the leeway to identify which specific Ontario hospitals you could and which you couldn't, and you said it was not possible.

If you want me to read the remainder of the thing, so that the record is clear, I'll do that. The answer is: "The minister is not able to determine the number of chronic-care patients who may be occupying active-treatment beds from current information reporting systems. Accurate information could

be obtained only by a medical assessment of each patient occupying an active-treatment bed.

"A number of district health councils have undertaken bed-accommodation surveys, which involve an assessment of the appropriate use of beds and facilities. This is an initial step in the local planning process to identify the need for various services, including chronic beds. Since these studies have taken place at various points in time and in different regions, it is not possible to project the initial bed-accommodation survey into a provincial statistic," which you just did. Whom do you believe?

**Dr. Dyer:** The first part of that is actually—

**Mr. Breagh:** I imagine you wrote that answer.

**Dr. Dyer:** I wrote that answer. The first part of it is absolutely correct. From the day we collect HMI data, or our OHIP data, we cannot identify the kinds of patients occupying beds. The only way it's identified is by an accommodation survey carried out in the hospital, usually by a physician, a nurse and the administrator, who go along and actually examine the sample of patients in the hospital—or all of them, for that matter. On that particular day they say how many patients are inappropriately in those beds in that hospital. That's the most accurate way of determining what kinds of patients are occupying those beds. We can't in any way specifically relate that to an overall provincial statistic.

**Mr. Breagh:** But you just did.

**Dr. Dyer:** I've given you estimates of what we believe to be a low side. It's not by any means a statistic. It's what we estimate from these surveys, taking the low side and relating that to the total number of beds, if the same kind of pattern holds throughout. As a matter of fact, it varies from hospital to hospital. I mentioned specifically we took 12 per cent; that's the low side of that.

If you take 12 per cent and assume that same pattern pertains, then you can guesstimate that 4,500 beds are those kinds of bed, occupied by those who are not receiving acute care. By no means is that an accurate statistic. I don't mean to pretend it is. It's an estimate.

**Mr. Breagh:** How is it that you can guesstimate that today and you couldn't guesstimate that three weeks ago?

**Dr. Dyer:** I think you were asking for specific numbers. We can't give you specific



numbers. We can give you numbers from accommodation surveys and, if you want to, you can do your own calculations. We have some specific surveys that hospitals and councils have done and you can examine those from a particular hospital. But by no means do we have them for the whole 35,000; don't misunderstand me.

**Mr. Breaugh:** I must say, Mr. Chairman, I'm more than frustrated, I am angry. I have tried by every means available to me as a member of this House to get information from the ministry. From the minister I get normal ministerial answers, so I put questions on the Notice Paper. I get this kind of answer. However, when it suits the ministry's purpose, they have the information I wanted. They not only have it, they flaunt it in my face on the first day of this committee hearing. That is a bit much.

Could I ask this one further question, because I know there are lots of people here today with questions for the ministry? What possible incentive is there now for those wonderful people such as those who work on the board at the Oshawa General Hospital, who do not fall in your classification of vertical planning and who did provide many new services and many innovative programs, so much so that the minister himself in his wonderful opening statement today chose to quote that example? They now face the same budget restrictions as everyone else—those who, the ministry assumes, were bad boys and girls, who didn't do the good thing.

People who did do the good thing, who did do what you are quoting as horizontal planning, are now in the same boat as everyone else. What incentive is there to be good, to talk to your neighbours, to be co-operative in your planning, to amalgamate services, when you wind up in the same boat as everyone else anyway?

**Dr. Dyer:** As a matter of fact, the Oshawa General is in an area that's under the four beds per thousand.

**Mr. Breaugh:** That's right.

**Dr. Dyer:** So there was no constraint in the sense of any identifiable surplus beds, and they got the maximum increase that was allowed. I'm not sure what it was; we can look that up for you, but they got the maximum allowable increase. In addition to that, there's a role study being done right now by the district health council in Durham region, to determine the roles of the various hospitals in Oshawa, Ajax and so on, and to see whether there may be any way of co-operative planning. But the Oshawa hospital is one we know is efficiently run.

Incidentally, the Oshawa hospital has recently announced it will engage the OHA survey to see whether savings can be achieved, and that's the first step for us to approach a situation where they say they have insufficient funding. They're now undertaking that survey and I'm sure they'll identify some potential savings. Those savings can be then put to their own use.

As you well know, they also started a very interesting day-hospital concept and that is on our high priority list for the funding of new and expanded programs. This year we haven't yet sorted out which hospitals and programs will be funded, but a number of them will be and they certainly are high on that list. In addition, as was the case last year, the hospitals that are operating at or below the bed standard, are the first on the list for consideration in any kind of an appeal process.

**Mr. Breaugh:** Wouldn't it have been a rational thing to provide them with the necessary funding to continue operating programs which you, as a ministry, say you admire, and are the kind of things you want to do? Why do you first stop them with a restraint program and then make them come begging to you for additional moneys to keep things in operation? Why that rather ridiculous process?

**Dr. Dyer:** We're not sure that they're as efficient as they can be as yet. We are not sure that they have gone through the total process of examining their operation to see their funds are being spent appropriately. We think they should go through the management consultant route that every other hospital does, to see whether the global budget they have is adequate. It may well be.

**Mr. Breaugh:** But the name of the game is that the group that squeals the loudest is going to get the funding.

**Dr. Dyer:** No, that's not the case.

**Mr. Breaugh:** What is the case?

**Dr. Dyer:** The hospital that has no surplus active beds, that goes through the steps of examining closely its operation to see whether the funds being provided are adequate or not, is then examined by our teams. If, as a result of that kind of close analysis, it's determined that hospital deserves additional funding, then it's certainly given consideration.

Last year, as you may know, in our entire final settlement there was still something like \$29 million that was recovered from hospitals; it was unspent. Hospitals received 4.5 per cent last year across the board. So there still are hospitals out there operating within the global budget they're receiving. As a matter



of fact, there are funds that are going unspent; \$29 million would be something like one per cent.

So in terms of good management, we have to go through the steps of finding out for sure the funds they have and the global budget they have are adequate to operate their programs. And they may be surplus to that. A number of hospitals are running surpluses still.

**Mr. Conway:** Just to be clear on that, in fiscal 1978-79, when the average increase was 4.5, there was, by your own figures, \$29 million unspent?

**Dr. Dyer:** Yes.

**Mr. Breagh:** I just want to close and turn it over to other members. But I frankly feel that people like those who served on the board of the Oshawa General, who did what the ministry wanted them to do, have been betrayed badly by the ministry this year. They played the game by your rules and they wound up getting penalized just like everybody else.

While you've been a little reluctant to name who the bad boys are in this business, you assume there has been a lot of lax spending and no control out there. I always thought it was the Minister of Health in this province who was supposed to be responsible for the tax dollars that were spent out there.

**Dr. Dyer:** As a matter of fact, the Oshawa hospital, when it undertook the day-care program, did so under the understanding it would do so within its global budget.

**Mr. Breagh:** And did it, and succeeded. And for their efforts they get nothing.

**Dr. Dyer:** No, they did so when they said they would operate it within their global budget. That happens around the province. We're finding out now there's a number of hospitals who made that commitment to the ministry but now find through growth of their programs they can't contain them within their global budget. Oshawa General was one of them. It isn't the ministry that forced that upon them; they wanted that program and they were the ones that made the commitment to operate it within their global budget.

They're the ones now that are coming back and saying it's been a growth program; it's grown beyond their expectations and they need additional funds. We don't think that's an unreasonable request, but we think it has to be examined in context of what their initial commitment was. And we have to look at their global budget and examine it from the point of view of whether they can operate within it. If they can't, then of course they

get certain consideration—no question about that.

**Mr. Breagh:** Pardon me for saying so, but it strikes me that after 11 years of no cost control, you've gone overboard the other way.

**Mr. Chairman:** I have on my list Mr. Riddell, Mr. O'Neil and Mr. McClellan. Mr. Riddell, I believe you have some questions with respect to the Goderich hospital. I should indicate they will be here tomorrow afternoon.

**Mr. Riddell:** Thank you, Mr. Chairman. Mr. Breagh's concluding remarks lead me nicely into my discussion, as I feel the people whom I represent in Goderich have been betrayed by the ministry as well. There is a delegation coming in from Goderich tomorrow, but I happen to be one member who is not what you might consider a political animal. If I wanted to make points I suppose I could discuss it tomorrow in front of the delegation, but I prefer to do it today.

I don't know whether Dr. Dyer was present when we had a meeting with the minister in the early part of April, discussing the hospital-bed reduction program in the Alexandra Marine and General Hospital, but there were at least six, if not eight, delegates present at that meeting and I was present as well. We got a firm understanding that the ministry officials seem to dispute.

I know when we were there the hospital was committed to the following: First, the Alexandra Marine and General Hospital would take the initiative in calling an early meeting of the administrators and chairmen of the hospital boards in Huron and Perth counties in order to establish the nursing-home needs in the two counties.

Second, the Alexandra Marine and General Hospital would immediately engage a firm of consultants to prepare a report in connection with potential cost savings at the hospital. The delegation understood that such a survey would be conducted at no cost to the hospital and they further understood that the cost of the consultants' fees would, with the approval of the ministry, be paid out of the savings they achieved.

[5:45]

The minister also made commitments and we thought we fully understood those commitments by the ministry, and they were as follows:

"It will consider our request for an increase from 10 chronic beds to 25 chronic beds, and it appears from the records file that the request will probably be approved at around 20 chronic beds."

"Second, in connection with the approval of further chronic beds, the ministry will restore the \$60,000 penalty to the Alexandra Marine and General Hospital budget for 1979-80.

"Third, the ministry acknowledges that the Alexandra Marine and General Hospital has peak periods that are difficult if not impossible to control, and the ministry will allow the hospital during such peak periods to increase its active beds from 43 to a maximum of 53, on the understanding that these additional beds would not be funded by the ministry but would be repaid out of the regular hospital budget and the ministry agrees that no penalty would be assessed against the hospital for the said increase during such peak periods.

"Fourth, the ministry will study the viability of small hospitals if the number of active beds is reduced below a certain minimum and, in the case of the Alexandra Marine and General Hospital, the ministry will look at whether it is feasible to operate a laboratory, X-ray department, surgery, emergency and outpatient departments with an active-bed allotment of fewer than 43 beds.

"Fifth, the ministry will study the change in referral patterns referred to in the brief filed by the hospital.

"Sixth, the ministry agrees that the hospital, within its own budget, may from time to time because of peak periods change the allotment between active and chronic beds."

That was the understanding the delegation came away from that meeting with, a commitment made by the minister, and also a commitment made by the hospital board, and it was shortly after that that I learned the ministry officials were disputing the commitment made by the minister. There has apparently been a misunderstanding which I brought to the attention of the minister through a question in the Legislature in April. I have yet to hear from the minister in response. He said he would definitely check this out with his officials. I have heard nothing.

I know that on April 12, the chairman of the Alexandra Marine and General Hospital board wrote to the minister outlining the various points I have mentioned here just now. On April 23, I received a letter from the hospital's solicitor indicating that to that point in time the hospital board had not received a response from the ministry.

In his letter, Mr. Murphy states, and I quote: "I took reasonably careful notes, and this was certainly my understanding at the meetings." That refers to the points I just

brought out. "Apparently some of the lower officials understood some of the commitments differently and that is the reason I am sending you a copy of this letter. We have not heard back from the minister as yet, but as soon as we do I will advise you, and if we have further difficulties we will have to arrange a further meeting with the minister."

He has never contacted me again, so I can only assume that Mr. Murphy or the chairman of the Alexandra Marine and General Hospital, Mrs. Josephine Berry, have not heard from the ministry on the various points that they raised in their correspondence.

What I want to know is, did we come away with a misunderstanding, or, after we left the meeting, did you people corner the minister and indicate to him that he had made commitments that you people didn't agree with? This leads me to another question: Who is running this ship? Is it the minister or is it the ministry officials, or—and I like to word my questions as kindly as possible, but I am compelled to say this—is the ministry trying to weasel out of the commitments that were definitely made and understood by the delegation at that meeting?

**Dr. Dyer:** Mr. Chairman, I don't know the exact details, but the minister did answer and a letter was sent to the chairman on May 16, and—

**Mr. Riddell:** A month and a half later.

**Dr. Dyer:** —the minister's commitments were laid out in that letter. He did undertake to fund the conversion of some 10 active beds to chronic care, on the establishment of need. If you want I think we can get the details of that letter and read them into the record.

As you well know, at the time he also encouraged the engagement of management consultants, which I understand the hospital has subsequently done. That engagement has demonstrated a substantial amount of money can be saved through a change, and adoption of the principles consultants have applied. I think it's fair to say, if the figures I have heard are confirmed—we haven't seen this confirmed at all—the amount of money is substantially more than the amount of money that was deficit funded and constraint funded this year. That can be provided through management techniques. That saving can be re-applied to the programs that hospital survey is suggesting.

The minister did make his commitment; the minister does make those commitments on his own—with advice, of course. That was made over his signature and we can get you details of that letter if you haven't seen it. I'd be



glad to do that. I think the minister is waiting for the response of the hospital in terms of the management consultants and what they intend to do about that. I think that would go a long way to resolving the problems of funding from the point of view of the programs they're talking about.

**Mr. Riddell:** Might I suggest, Mr. Chairman, the details of the minister's letter be available for tomorrow when the delegation will be here? They are certainly frustrated in trying to draw up a budget and going by what they understood the minister to say, and when that was apparently disputed by some of the ministry officials, they just don't know where they stand. This is one of the reasons they're coming tomorrow.

If the minister's commitments at the time of the meeting had gone as indicated, I question whether there would have been a need for the delegation to come tomorrow, but they're definitely going to be here. They're going to have to get some questions answered and if you could have the details of the letter here, I'd appreciate it.

**Dr. Dyer:** As you well know, Mr. Chairman, the minister has made the commitment not only to Goderich but also to Wingham, for their interadministrative planning group to fund a study. I think they've already considered the consultants to do that study, to look at the extended-care needs for that area, because that's one of the problems, as you well know. It's extended-care patients who are plugging up their active-care beds, and the ministry has made a commitment to fund that study. As soon as we get the proposals from the group as to how that study will be done, then we'll find a way to fund that study. We're as anxious to have that done as the community.

**Mr. O'Neil:** Dr. Dyer, you made several references during your speech to district health councils. I know in our area, in the Quinte area—Belleville, Trenton, Picton and around there—we don't have a health council. They've chosen not to enter into it. What's going to happen in the areas that do not have district health councils? How will these problems be handled?

**Dr. Dyer:** In the mechanism for the co-operative planning, one of the major thrusts, one of the major mechanisms, is the adoption of a district health council as a planning group. Although no councils are forced on any area, when we come to that kind of interservice, broad-based planning—that is, not only institutions but home-care programs and community programs—an area that doesn't have a council leaves something

lacking as a community group we can ask to do that kind of planning. At the present time, they don't have a district health council in Belleville, as you know, but Kingston does have a hospital council, a co-ordinating complex council. That council has done some very effective planning for their hospital complex, but it leaves us with a problem in trying to plan that in conjunction with the outreach programs.

**Mr. O'Neil:** There are those who fear, where some of the district health councils haven't worked out, that the government is asking these people to make some of the hard decisions that it doesn't want to make. You're forcing them to take on a lot of the problems that have grown over the years and to make these hard decisions to close certain wings or certain services. They take the brunt of it, and you people don't.

**Dr. Dyer:** I don't think that's the feeling of the councils across the province. I've mentioned three of them today that have engaged very actively in rationalization of services. It's not their impression that they're the front men, if you will, for the ministry. It's their impression that they're intimately engaged in community planning. You're welcome to discuss that with any of them, for example, the Essex council, or the Brant council, or the Cochrane council in the Timmins area.

In Belleville, as you know, there's an identifiable need for some 48 chronic beds in that area. There is also an identified surplus of about the same number of active beds. It's one of these areas where there is a very good potential for conversion. This year the Belleville hospital has had constrained funding for 25 active beds against the four-bed standard. The hospital has now made application to convert those 20 beds to chronic. That's fine, we'll proceed with that. We can proceed in a vertical planning mode with that hospital and we will do so. We hope they will reassess that and perhaps convert the entire 48 to meet the chronic-care needs in future years. This year it looks as if we have a way to resolve the imbalance of chronic-care needs versus surplus active, at least as an interim measure, and to set up the plan to expand that. A chronic-bed program there of 25 additional beds would be a viable chronic unit.

**Mr. O'Neil:** I feel another problem exists. The community of Trenton over a number of years has built up an excellent hospital through private funding, donations, fund-raising drives and everything else. The board of directors have worked in such a way that



the budgets have been cut back. They've cut them down themselves; they've cut out a lot of the fat. They have come up with one of the lowest per-bed costs across the province, I would say. I don't know whether you know what the figures are. I don't have them here but they are low.

Then you come along with your increase in budget of 4.5 per cent and you say you're going to base it on their existing budget, after they've trimmed it a lot. There are a lot of other boards across the province that haven't trimmed. They've built fat into it. I don't really think it's fair to some of these hospitals that have done their job over the years.

We talk about some of the government departments which spend their money because they want an increase every year. I think this exists in a lot of our hospitals throughout the province. I'd like to ask you how do you handle something like this to be fair with some of these hospitals that have worked so hard to do a job for the ministry in keeping costs down.

**Dr. Dyer:** As we indicated, if that hospital is prepared to convert beds to meet the needs that are there, then it would get a reinstatement of funding at least for those 25 beds. That'll bring them up to the base standard without any constraints, other than the basic one that everyone got at 4.5 per cent across the board. This has not been done to my knowledge at Belleville.

**Mr. O'Neil:** I'm talking about Trenton.

**Dr. Dyer:** I'm sorry, I thought you were talking about the Belleville hospital. To my knowledge, Trenton either has not engaged management consultants—

**Mr. O'Neil:** Yes, they have. Trenton has brought in management consultants over the last short while. When these small communities have done a job and built a beautiful hospital and looked after it properly, there's always the fear that when there are larger centres around that obstetrics or paediatrics, as happened in Trenton a couple of years ago, are going to be closed out and maybe moved to a larger centre or done away with.

These are small community hospitals. They're busy and they can't always go on this ratio of beds per thousand because of the job they do. Last night I had to enter a patient at the Trenton hospital and there was one spare bed in the Trenton hospital; all other beds were full. There is that fear that they're going to lose their identity to a larger hospital or to a larger centre or that possibly they may be turned into chronic-care hospitals.

[6:00]

You probably have heard these fears before, but we like to feel that our smaller hospitals—or even some of our larger ones in the centres—are going to be looked at, and if they require additional funding because of them trimming a lot of the fat over the years, you're going to look at it. We've received quite a hassle from the ministry over the last number of years about Trenton's budget in particular. Sure, they say they're going to look at it, and there have been some additional funds, but as I say, it's an awful hassle to go through in order to get these things.

**Mr. Cooke:** Could I just make a couple of brief comments?

**Dr. Dyer:** I'm sorry, I'm looking to see whether we have the results of their management consultant study.

**Mr. Cooke:** Maybe you can pass that on to him.

**Dr. Dyer:** It's not on our record, but that doesn't mean hospitals haven't done it. Some hospitals, of course, have done this on their own and we encourage them to do that. I haven't got that on the list, so I don't know what the outcome is.

**Mr. Cooke:** Without going over time too much, I can't let today go by with all these glowing comments of the Windsor-Essex agreement without asking Dr. Dyer a couple of questions. First of all, you neglected to mention—or I didn't hear you mention—that one of the major hospitals in the city didn't sign the agreement, Metropolitan Hospital. So, we must make sure that the members of the committee understand that.

Second, it's always confused me and I just don't understand why you would do a bed-allocation study after the agreement and after all the major decisions have been made. You've decided on the number of chronic-care beds, you've decided on the number of active-treatment beds, and now you're going to do a bed-cancellation study, or a bed-use study. Could you explain that rationale to me? I'm sure there must be some rationale that slips by me.

**Dr. Dyer:** It must be a study undertaken by the district health council. We haven't requested it from the Ministry of Health.

**Mr. Cooke:** It is being done, but the agreement was also done by the district health council.

**Dr. Dyer:** The agreement did not embody a utilization study per se.

**Mr. Cooke:** I understand that. What I'm asking you is why would a bed-utilization study be done after the major decisions had been made?

**Dr. Dyer:** I think they may be trying to establish shifts in utilization of the different hospitals as a result of the move.

**Mr. Cooke:** The reason for the bed-allocation study is quite clear; they want to know how many active-treatment beds are being used by chronic-care patients.

**Dr. Dyer:** That's an accommodation study, I'm sorry.

**Mr. Cooke:** Accommodation study then. Which is exactly the kind of information you need to decide what kinds of beds are needed in a city. Yet the major agreement has now been made and maybe you can help—

**Dr. Dyer:** I think that's very logical. They should really undertake an accommodation study to find out what their future expansion needs are for chronic care. Chronic care is one of the major identifiable requirements in our community, as you well know. They are expanding the chronic-care facilities; they're now enlarging and will be entering into a chronic home-care program.

**Mr. Cooke:** That commitment has been made. We'll wait to see whether it's followed through. However, you still haven't adequately explained it to me. One of the reasons for this bed-allocation study is to find out which beds are being misused, right?

**Dr. Dyer:** It's really to determine specifically the number of beds required for acute care, the number required for chronic care, and the number required for extended care.

**Mr. Cooke:** Wouldn't that be helpful information before the agreement was made?

**Dr. Dyer:** Yes.

**Mr. Cooke:** But the agreement was made ahead of time.

**Dr. Dyer:** Yes.

**Mr. Cooke:** Can you explain the logic of that for me?

**Mr. Breaugh:** It's simple. First you decide what you want to do and then you find out why you wanted to do it.

**Mr. Cooke:** What I'm trying to get at is that the ratio of four active-treatment beds per thousand, and the other ratio of 3.5 that will be met in 1981, has been made with no information as to the needs, at least in the Windsor-Essex area. That information is not available. Do you have the bed-utilization study yet, or the bed-accommodation study yet, from Windsor?

**Dr. Dyer:** No, I don't.

**Mr. Cooke:** Would you table with the committee the ones that you do have available?

**Dr. Dyer:** The ones we have available are not from Windsor. Is that what you mean? From other areas?

**Mr. Cooke:** Those from the province are helpful. Any others in any other areas of this province. Would you table those with this committee, because I think it would be very useful information?

**Dr. Dyer:** Yes, we'll table them.

**Mr. Cooke:** I would assume you will be getting the Windsor study.

**Dr. Dyer:** Presumably.

**Mr. Cooke:** Will you table that with this committee when that becomes available to you? Please.

**Dr. Dyer:** Yes.

**Mr. Cooke:** One other comment, because I know that you want to leave.

**Dr. Dyer:** I think you should realize that, if it's done by the hospitals or the council, the ministry doesn't own that study.

**Mr. Cooke:** No, I realize that.

**Dr. Dyer:** We like to do that, with their agreement.

**Mr. Cooke:** Just for your information, to update you on the latest on the Windsor agreement, I might point out that there was an article in the paper on Friday night regarding the 12 active-treatment beds that were to be closed in Metropolitan Hospital to meet the four per thousand active-treatment beds. As of April 1 they still had not been able to close those beds because of the demand for hospital beds. Not only do they have those beds open, but they have to use the hallways and emergency room to accommodate people as well as having to turn away people who shouldn't be turned away. I don't know how the hospitals in the Windsor-Essex area are possibly going to cope in the winter when the demand for active-treatment beds always increases, as has been admitted by the minister in the House to me on several occasions.

**Dr. Dyer:** Part of the problem is that in the planning and rationalization process, the Met was asked to join with the other hospitals. Representatives were here at a meeting and when they heard of the problems with some of the stuffed emergency departments, they offered to take any loads they have. But they were told by the Met they weren't required to do that. So, I think there's a real need to co-operate in that community.

The other side of that situation is that the Metropolitan Hospital—and I'm not faulting them—are continuing to feel that they need to provide services in all areas, and they're continuing to provide obstetrical and paediatric services in that hospital. The rationalization process wanted to see whether they could accommodate those elsewhere, and as a matter of fact, the paediatric department could be accommodated at the Hôtel Dieu. It could well be accommodated at the Hôtel Dieu and probably might go there eventually. That would free up a considerable amount of space for medical-surgical beds in the rationalization process. When the hospitals and the district health councils got together with the hospital, they said to them that perhaps the identifiable role should be the trauma centre for that community, because that's the role they want to have. But they were asked if they wanted that role as well as being the paediatric hospital and the obstetrical hospital and the other things as well.

I think that's what I mean by co-operative planning. They haven't as yet, for their own reasons, engaged in that, and we encounter problems when that occurs. But I think you should encourage them to get back to the bargaining process.

**Mr. Cooke:** I'd like to go into much more depth about the Windsor agreement, if we had the time; but it's not all what you people have cracked it up to be.

**Dr. Dyer:** It's not an easy process. I mentioned that at the beginning, Mr. Chairman. It's a difficult process and a very complicated one, and it will take a lot of work to make it work, I agree.

**Mr. O'Neil:** Mr. Chairman, I have one question that I wanted to end with and I realize that others want to get on, too. Could I ask Dr. Dyer if somebody from his part of the ministry would be kind enough to either write me or be prepared to sit down with me to discuss both the Trenton and the Belleville hospitals and give me some idea on the budget situation at the present time on both hospitals, regarding beds and so on?

**Dr. Dyer:** Yes, we'd be glad to sit down with you, any time you want. Give me a call and we'll get a group together and have our statistics and data and talk about it.

**Mr. Chairman:** I would just like to say, Dr. Dyer, that from a personal standpoint I've been trying to reassure myself the ministry isn't penalizing efficiency and rewarding inefficiency. Perhaps we can deal with that question tomorrow, but I just haven't got that assurance so far, and I would appreciate it if you could respond to that some time. We'll be together for a few days, I assume.

**Mr. Breagh:** Just before you close off, Mr. Chairman, do we have the assurances that ministry staff will be floating around or skulking about the corridors here, so that if we do have questions that are raised they'll be available?

**Mr. Chairman:** Yes.

**Mr. Breagh:** Mr. Chairman, as to your problem, I'd be more than happy to chair the session for a few hours while you get these frustrations off your chest, as well.

**Mr. Chairman:** Thank you, Mr. Breagh. The committee is adjourned to reconvene tomorrow after routine proceedings.

The committee adjourned at 6:09 p.m.



## SPEAKERS IN THIS ISSUE

---

Breaugh, M. (Oshawa NDP)

Campbell, M. (St. George L)

Cassidy, M. (Ottawa Centre NDP)

Conway, S. (Renfrew North L)

Cooke, D. (Windsor-Riverside NDP)

Gaunt, M.; Chairman (Huron-Bruce L)

Johnston, R. F. (Scarborough West NDP)

Kennedy, R. D. (Mississauga South PC)

McClellan, R. (Bellwoods NDP)

O'Neil, H. (Quinte L)

Riddell, J. K. (Huron-Middlesex L)

Rowe, R. D. (Northumberland PC)

Timbrell, Hon. D. R.; Minister of Health (Don Mills PC)

From the Ministry of Health:

Bain, W., Director, Institutional Operations Branch

Dyer, Dr. A. E., Assistant Deputy Minister, Institutional Health Services



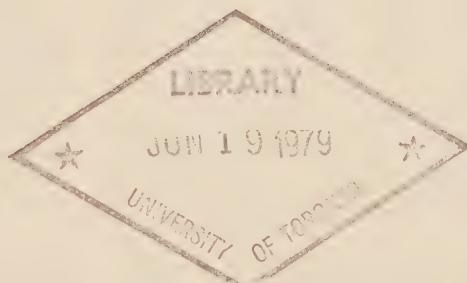
No. S-19

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Tuesday, May 29, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.



## LEGISLATURE OF ONTARIO

TUESDAY, MAY 29, 1979

The committee met at 4:03 p.m.

### MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

(continued)

**Mr. Chairman:** We have a quorum and I am going to call the committee to order. Sorry for the delay, for which I and the committee apologize, but question period was rather lengthy. That was the start of the delay. Further to that, it was my clear understanding that we would have some ministry people here. Am I correct in that assumption? I understood that would be the case and I understand that the ministry people are on their way over.

**Mr. Boddington:** Dr. Dyer is coming.

**Mr. Chairman:** Thank you. We have some members of the Wingham Hospital board here with us today. Wingham is the first one of a long series of hospitals which will appear before this committee. As you know, this committee is charged with the responsibility of conducting hearings into the hospital bed-cut program. We will do some travelling in carrying out our duties with respect to those hearings, and then we will make a report to the Legislature on our findings and include in those findings any recommendations which the committee might see fit to make.

To commence the hearings today, we are pleased to have Mr. Jack Hodgins, the chairman of the board, Wingham and District Hospital, Mr. Norman Hayes, the administrator of that hospital, and Mr. John Mann, who is the chairman of the citizens' committee. Over at the other table we have Mr. Barry Winger, who is a past chairman of the board, Mr. Boris Milocevic, who is vice-chairman of the board, Mr. Robert Campbell, the solicitor to the board. So gentlemen, welcome to the committee, and I'll turn it over to Mr. Hodgins.

**Mr. Hodgins:** Thank you, Mr. Chairman. The Wingham board appreciates this opportunity to meet with your committee, and present our position, as far as status quo in the Wingham Hospital Beds Association is concerned.

You all have the brief that the board and the citizens' committee prepared. I believe your chairman has distributed it to you. I will go through an addendum to this brief, and bring up the high points of it, and possibly make you all a little more acquainted with the situation. There's one error in the brief on the first line. It's printed as May 10 and it should be April 10.

The brief that was presented to the Minister of Health Tuesday, April 10, 1979 runs to 18 pages plus appendices. This addendum will attempt to précis that brief and will add some additional comment which the committee might wish to consider. The historical section of the brief outlines the services provided at the hospital. These are comprehensive for a hospital of our size. Of special note are those services such as discharge planning, meals on wheels, committee for the home-bound, and home care which are based at the hospital, or heavily utilized through the hospital. They are intended to keep our clients out of the hospital and in their own home environment where possible, in nursing home beds as a second level, and the hospital beds only when strictly required, and as a final choice. We do not admit to our beds unnecessarily. We do not keep people in beds any longer than we must. Our hospital average length of stay confirms this. After a treatment of 7.6 days, newborn 4.9 and chronic 75 days.

The next section of our brief deals with admissions. We admit from the north part of Huron county and the south part of Bruce county. These areas contain a large portion of elderly citizens. The social and demographic unit of the TEIGA is a study dated March 25, 1977, contains figures showing the percentage of 65 and over to be 13.5 per cent in Bruce and 12.9 per cent in Huron.

This places us fourth and sixth in the province, at a time when provincial average is 8.6. The elderly require a much greater proportion of health care. The next section of the brief deals with productivity. Wingham and District Hospital has demonstrated a steady productive increase since 1973. It is a pity that this now appears to have been self-defeating. We are penalized, even though we are efficient.

A description of area weather, transportation, and traffic follows. In these sections we clearly outline the problems faced in our part of the province. It is perhaps ironic that our original meeting with the Minister of Health (Mr. Timbrell), set for Friday, April 6, 1979, had to be cancelled because the area was paralyzed by a late spring snow storm.

We feel that our brief demonstrates very clearly the necessity to examine each hospital's case on its own merit. It is not sufficient to apply blanket bed formulae no matter how fair these seem to be. These formulae, moreover, are being based on available monies, rather than on an accepted methodology derived from need studies. The Bridgman formula for active beds, from the World Health Organization, suggests an optimum occupancy for a 100-bed hospital lies somewhere between 75 per cent and 80 per cent.

Active occupancy in 1979 ranged from a high of 91 per cent to a low of 48 per cent, and averaged approximately 76 per cent for 82 beds in the active category. The ministry is suggesting we cut to 51 active beds by 1981. This translates into occupancies of 147 per cent, 71 per cent and 122 per cent. Over the past five years the number of admissions to the Wingham and District Hospital has remained constant at about 3,000 per year, while their length of stay and days of care was declining—evidence, surely, of efficient resource utilization.

We do not feel we can cut our beds without jeopardizing the care we give those we serve. We think our service is rendered efficiently and on a cost-effective basis. Finally, we think the entire question of bed closures in small hospitals requires additional study. The restrictions we face, because of patient mix and flexibility, become more and more onerous as the number of beds declines. When this is combined with penalties for non-closure of beds the situation becomes desperate.

That completes the addendum of our brief that was submitted to the Ministry of Health. I would like to entertain any questions that you might have or any of the committee members might have.

**Mr. Chairman:** Fine. Is there anyone else in the delegation who would like to make some comments at this point, or would you prefer to go directly to questions. Mr. Ramsay?

**Mr. Ramsay:** Thank you, Mr. Chairman. The first question I have deals with the hospital's average length of stay. According to your brief you indicate that for active beds it's 7.6 days. From some experience I've had in the hospital-care field, that seems

to me to be a very good figure. The hospital I had affiliation with tried to work to around eight to 8.2 days. I was led to believe that the national average, or at least the provincial average, was somewhere around nine. Is that correct? That nine is the provincial average?

**Mr. Hayes:** It's close.

**Mr. Ramsay:** While you're looking that up, I was wondering if this has occurred—over what period of time have you been able to bring it down to what I consider to be a pretty commendable figure?

**Mr. Hodgins:** We've been bringing this figure of days of active treatment—I would say it's been declining in the last five years because we've been working on it very diligently.

**Mr. Ramsay:** From about what figures?

**Mr. Hodgins:** When we started out it was 11.5.

**Mr. Ramsay:** Eleven-five; and in five years to the figure you have. I'd like to ask, if I could, how you arrived at the figure you indicated in your brief. You said that Wingham serves a population of 30,000 plus. Is this what you consider to be the area that supports your hospital?

**Mr. Hodgins:** Yes, it is. It's a very close estimate of the population we serve.

**Mr. Ramsay:** I have trouble relating to population and referral figures. The ministry refers to referral figures, which aren't necessarily population figures. I was wondering if you could comment on that.

**Mr. Hodgins:** These are population figures within the radius of the area from which we draw patients to our hospital.

**Mr. Ramsay:** I'd be interested in hearing what your administrator might have to say about referral figures as outlined by the ministry. How do they arrive at their figures as compared to the use of population figures?

**Mr. Hayes:** Mr. Chairman, through you to Mr. Ramsay, the methodology is based on the patients who actually come to our hospital, as a proportion of the total number of patients who go to any hospital centre. Our present referral population is somewhere around 13,500, split into four categories: zero to 14, 15 to 44, 45 to 65 and 65 and over; then an OBS group, obstetrics group, that relates to the 15 to 44 group.

[4:15]

The area we serve has somewhere between 30,000 and 35,000 people in it. Not everything that has to be done can be done in a hospital of our size. Many things have to be referred to tertiary hospitals for treat-



ment, and our tertiary hospitals, generally speaking, are the three in London, Ontario.

**Mr. Ramsay:** In other words, the ministry figures that they're accepting for your service population are considerably less than what—

**Mr. Hayes:** That's quite correct.

**Mr. Ramsay:** Could you give me a figure, the difference?

**Mr. Hayes:** Their figure comes out to approximately 13,500; we accept that on the basis of the actual referrals to the hospital.

**Mr. Ramsay:** But you feel that a more realistic figure is 30,000?

**Mr. Hayes:** That is the number of people living in the area. Not all of those people get sick in any given year, of course.

**Mr. Ramsay:** No.

**Mr. Hayes:** Would you like me to answer your question about lengths of stay?

**Mr. Ramsay:** Yes, I would, please.

**Mr. Hayes:** This is taken from the Ministry of Health publication Hospital Statistics for 1978-79. In our group, 100-bed hospitals with long-term care, the average active care is eight days in the province of Ontario. Our average for that period of time was 8.7 days, overall.

**Mr. Ramsay:** All right. I think that is part of a broader question that I wanted to pose; that is, what action has your hospital taken recently to reduce the dependency on active-treatment, inpatient care?

**Mr. Hayes:** We have a very active placement program through a discharge planning co-ordinator, who was appointed in 1974. When a patient enters the hospital, either in active or chronic care—we do admit directly to chronic care—she begins a process of placing that patient back into his own home in the case of an active-care patient, or into a nursing home, a home for the aged, or a boarding home in the case of a patient who requires some assistance.

We also participate fully in the current home care program that functions in both Huron and Bruce counties, although that program is aimed at active care rather than chronic care. We have managed to get some assistance through that program.

**Mr. Ramsay:** What about things like day surgery which the minister referred to yesterday in his comments?

**Mr. Hayes:** We do day surgery at our hospital—not as much as we'd like to. We really don't have the facilities for this; nor do we have the facilities to run a day-care program for a chronic program. Part of our presentation to the ministry was for capital

funding to renovate our facilities to allow us to do those things.

**Mr. Ramsay:** Does your hospital have an operating deficit?

**Mr. Hayes:** No, we do not.

**Mr. Ramsay:** I'm not suggesting for a moment that your hospital does this, but I know there are hospitals in the province that will put chronic patients into active beds and therefore save some money towards balancing their budgets.

**Mr. Hayes:** At our hospital we are on what is known as a melded rate. We get the same amount of money—so much per diem—whether the patient is in an active bed or in a chronic bed; so there is no advantage to us in that kind of exercise.

**Mr. Ramsay:** I want to make it clear that I'm not suggesting you are doing that, but I have heard that it's being done and done successfully by some administrators.

I understand—and I'm reading from the minister's statement yesterday—that on September 28 there will be a conference of small hospitals in the province. He says, "At this conference I expect there will be a thorough examination of the budget and bed concerns of the smaller community hospitals, and indeed a thorough examination of the role of these facilities during this period of evolution." Would you have any comments to make on such a conference?

**Mr. Hayes:** Certainly we wish to participate in such a conference. Within our brief we discuss in one portion of it the Bridgman formula for active beds. This is a formula that was derived by the World Health Organization—it is from a World Health Organization publication—that sets out optimum utilization rates for smaller hospitals. The small hospital is faced with some fairly basic problems in terms of patient mix, male-female mix, in terms of the number of beds that must be let for emergencies, in terms of staffing patterns below which one cannot go and still maintain services. All of these are factors that create difficulties for us.

As our number of admissions falls, the number of beds may fall. But as long as the number of admissions remain constant—as ours have over the past five or six years at about 3,000 a year—we are faced with delivering that service year in and year out and we deliver it at about 75 per cent occupancy. According to the Bridgman formula that's about where it should be.

**Mr. Ramsay:** Fine.

**Mr. Chairman:** I was critical of the committee a couple of weeks ago for some of the



members going on at length so I will try to just ask two or three very short questions and then pass it along to others who do have questions.

To go back to the point I talked about—the difference between chronic and inpatient, and the shuffling of beds in order to get your budget balanced and so on—you answered that you have a melding formula. Do you actually, though, have chronic or nursing patients in your active-treatment beds?

**Mr. Hayes:** No, sir, we do not.

**Mr. Ramsay:** On the 3.5 active-treatment bed guideline—where do you fall in that respect?

**Mr. Hayes:** We would have to reduce by 31 active-treatment beds.

**Mr. Ramsay:** Is there not a cushion provided for hospitals of 100 beds or less? Is that included in the cushion?

**Mr. Hayes:** We have a 10-bed cushion this year. We had to reduce, initially, 14 beds in the 19; that brought us down to the four-bed formula. The next step was to 3.75 and the step beyond that was to 3.5; so in three successive steps we would have gone down 51 beds. It's my understanding that formula does not allow for that cushion to remain after this first year.

**Mr. Ramsay:** Could I ask the ministry if that is correct, if the cushion does not remain after this year?

**Mr. Breagh:** You can later on, sure.

**Mr. Ramsay:** I thought that's the reason ministry people were here, so that they could answer any of those questions that came up.

**Mr. Chairman:** If Dr. Dyer wishes to come up to a microphone—

**Mr. Ramsay:** All he has to do is say yes or no. He can say it from there. It's just yes or no.

**Dr. Dyer:** Mr. Chairman, no decision has been made in so far as the change in the 10-bed cushion is concerned. As a matter of fact, that is one of the purposes of the small hospital conference, to address that matter. It has been raised by a number of hospitals. I think it's a realistic sort of thing that we have to consider in the future. Because of the need for flexibility in small hospitals, perhaps that's a viable concept to continue. There is certainly not any decision to discontinue that.

**Mr. Conway:** If I might ask a supplementary, Dr. Dyer: As the conference is not being held until September and a decision being taken presumably at that time, would you not need a little more time in which to make those kinds of decisions, to plan for the fiscal year 1980-81?

**Dr. Dyer:** I don't think so. That's about the time we will be planning for fiscal year 1980-81; we'll need a decision shortly at that time, certainly.

**Mr. Breagh:** So in response to Mr. Ramsay's question, you don't have a yes or a no.

**Dr. Dyer:** There is no decision as yet, Mr. Breagh.

**Mr. Breagh:** Not a yes or a no.

**Dr. Dyer:** That's right. All I can say is that the policy has been adopted this year and there is no decision to retract that policy. The policy is of a 10-bed cushion this year and there has been no decision to retract that policy. So in a sense it's still in place.

**Mr. Breagh:** Is that closer to a yes or to a no?

**Mr. Turner:** I think it's a very definite answer, with all due respect. If you recall what Mr. Ramsay asked Dr. Dyer has given a response to that.

**Mr. Breagh:** Yes, I do.

**Mr. Turner:** There is not any change nor is there any change contemplated at this time.

**Mr. Breagh:** We are getting closer to yes. So, one more response to that question and we may have a yes.

**Mr. Turner:** Keep on trying.

**Mr. Conway:** Do you think it might be useful to have Dr. Dyer at the front so we can direct the questions more easily?

**Mr. Ramsay:** I have one final question. Yesterday there was considerable discussion about the use of management consultants by the hospital to recognize, and hopefully to establish, areas of saving. Has your hospital taken steps in this direction?

**Mr. Hayes:** Yes, we expect to introduce the OHA program sometimes in September. They are not able to start before then.

**Mr. Ramsay:** The Ontario Hospital Association?

**Mr. Hayes:** That's right. They are cost containment programs. They'll be looking at all departments, I believe with the exception of nursing.

**Mr. Ramsay:** This is supplementary to that question. How does this compare with the private consultants available whom many hospitals seem to be using?

**Mr. Hayes:** I would think it's comparable but cheaper. It's being funded partly by the Ministry of Health, so it must have some validity.

**Mr. Ramsay:** Fine. Those are all the questions I have.

**Mr. Kennedy:** Could you give some detail as to the present status of that? Are they at work now?

**Mr. Hayes:** They are. They have done their four test hospitals and have identified savings in all four of them. They are of a fairly minor nature in the smaller hospitals, but what they did manage as far as the smaller hospitals are concerned is to create a climate for cost containment with the department heads. Because of that there is considerable value to the course.

**Mr. Kennedy:** I'm sorry, I missed something there. Are they doing four other hospitals?

**Mr. Hayes:** No, they are starting into a whole range of hospitals now. They did four pilot hospitals.

**Mr. Kennedy:** Oh, I see. Will they now be addressing themselves to yours?

**Mr. Hayes:** Yes, or whoever requests their services. That's correct.

**Mr. Chairman:** Mr. Cassidy?

**Mr. Cassidy:** I just want to read part of the minister's statement of January 19 into the record, Mr. Chairman. When he announced a 3.5 bed standard for hospitals in southern Ontario, he said, and I quote, "This year we are prepared to allow hospital centres containing hospitals with 100 beds or less to stay as high as 10 beds above the guideline before the budget base is affected." That was the announcement of the 10-bed cushion, but it was specifically related only to this year. My understanding of plain English is if he says you're going to move to 3.5 beds they have to plan accordingly. The minister, as we learned yesterday, isn't telling hospitals what their allowable beds are going to be next year or the year after that. That would mean that as far as the Wingham and District Hospital is concerned, in this current fiscal year it loses 14 beds but get ten back, so the net loss is four.

**Mr. Hayes:** No, I'm sorry; we lost 24 beds, Mr. Cassidy, and got ten back.

**Mr. Cassidy:** I see, okay. You lose 14 this year, and you lose 14 the year after, and you lose three the year after that. Have you had any indication from the ministry the 10-bed cushion would be extended beyond this year?

**Mr. Hayes:** No, we have not, sir.

**Mr. Cassidy:** I see. Whatever Dr. Dyer is saying, there has been no communication with your hospital; and that's despite several meetings, both with the minister and with Dr. Dyer.

**Mr. Hayes:** That's correct, sir.

**Mr. Cassidy:** Can I direct that question to Dr. Dyer? The minister says, "This year, there's a 10-bed cushion" but now you're saying, "No, the policy is going to change." Can we expect the 10-bed cushion will apply throughout this program?

**Dr. Dyer:** I think that's a good question.

**Mr. Cassidy:** I think it is, too.

**Dr. Dyer:** The minister has answered it on other occasions when he said—as I did before—the policy was adopted this year and there is no decision yet to change that. The policy has been adopted this year and I really can't say if it will be continued next year or not. As a matter of fact, the decision on that is deliberately being delayed until the small hospital conference to see the reaction and developments at that conference. I'm not trying to hedge on the question, it's just that we don't have a policy. I do understand there are some misconceptions around the province that it will be only for this year, but that has not in any way been stated.

**Mr. Cassidy:** With respect, Mr. Chairman, when the minister was here yesterday, and I don't know if the assistant deputy had a role in drafting his statement, he said, "We knew there was a limit below which the small hospitals could not function effectively as viable institutions. It was for that reason we provided a cushion of up to 10 beds above the guideline for hospitals with fewer than 100 beds for the 1979-80 budgets." That's just for this current fiscal year. Surely if the matter of 10-bed cushion in future years was being considered by the government we would have had some indication from the ministry. I don't know whether you can reply to this, as a civil servant, but I ask you to share our sense of frustration when we hear one thing when we press, and we hear other things when the minister is deciding to put the heat on a hospital like Wingham.

[4:30]

**Dr. Dyer:** We should certainly clear the record and make it absolutely clear that a policy adopted this year has not been rescinded; therefore it could well be continued next year. It has not been rescinded as a policy.

I want to make clear that we also have not discussed the implications at this time of removing it or not removing it because we want to see what the interest is in this. By the same token, I might add that the year before a policy was adopted of an extra



allowance for small hospitals. That was for the year 1978-79. At that time it was six per cent for small hospitals as opposed to 4.5 per cent. The same kind of policy was continued this year of an extra allowance of 5.3 per cent for hospitals under 50 beds. It was a policy adopted in one year that was continued.

Mr. Cassidy: I don't know whether I can direct this question to Dr. Dyer before we turn to the people from Wingham. Is it therefore possible, if you're going to reconsider the 10-bed cushion and possibly reinstitute it for next year, that the ministry, in view of the very serious implications and the damage to health care across the province that's being done by the policy, might in fact abandon its standard of 3.5 beds per thousand in southern Ontario by this time two years hence?

Dr. Dyer: With respect, Mr. Chairman, I don't think I can answer that question.

Mr. Breagh: You just said that you're going to continue with an additional 5.3 per cent increase for small hospitals this year.

Dr. Dyer: On the adjusted base 5.3 per cent was allowed for hospitals under 50 beds as compared to 4.5 per cent that was allowed for hospitals over that number on the adjusted base.

Mr. Breagh: You're saying all these numbers that we're getting from the hospitals are wrong and that they have an additional 5.3 per cent increase. You just said that.

Dr. Dyer: No, I didn't say that.

Mr. Breagh: Will you please tell me what you did say then?

Dr. Dyer: Let's take an example of a hospital that has no surplus active beds; and there are a number of them around the province. A hospital that has no surplus active beds and is over 50 beds in size, got a 4.5 per cent increase of its inpatient activities. It got a 5.3 per cent increase on the outpatient and chronic components of its operation, without any deduction because there are no surplus beds. If the hospital was under 50 beds, it had a 5.3 per cent increase for the entire operation. There was an added amount for hospitals under 50 beds.

Mr. Breagh: Then there are a lot of hospitals out there operating on wrong information because they don't seem to think that they do have any increase.

Dr. Dyer: The difference is that if a hospital had surplus active beds, for which there was a constraint applied, then that constraint balanced off in some cases the amount of

money as the inflationary amount that was issued.

Mr. Cassidy: I'd like to go back to Wingham, to Mr. Hodgins and Mr. Hayes. Since the ministry says it's going to penalize you this year to the tune, I believe, of \$168,000 for having excess beds, presumably that must mean that you are running at about 75 per cent of capacity but are staffing to about 90 per cent of capacity. Is that correct?

Mr. Hayes: It is not.

Mr. Cassidy: To what extent of your capacity do you staff?

Mr. Hayes: We staff at our average capacity of 75 per cent.

Mr. Cassidy: If you staff at 75 per cent, then what is the savings that will be amassed in the Wingham hospital by reducing your number of beds by 14 beds this year?

Mr. Hayes: One presumes that as the number of beds falls, the number of staff also falls with it. And indeed, with staffing at 75 per cent occupancy now, as we increase the number of people that go into beds, we also increase the number of part-time people that we employ. We are at a very difficult situation in trying to reduce the number of people because we've come down to the core now, at 75 per cent, and we're faced with the probability that if we continue to reduce the number of beds of having to transfer people from full-time to part-time status, we'll have to make lay-offs.

Mr. Cassidy: If you are staffing at 75 per cent and that's your occupancy right now, how does your staff ratio compare with other hospitals across the province, in relation to the number of patients or patient days that you have in the Wingham hospital?

Mr. Hayes: We were at about 11.9 last year. Those figures are in the brief.

Mr. Cassidy: Which compares with the provincial average for comparable hospitals?

Mr. Hayes: Well over 12, I believe, Mr. Cassidy. Again I have that information somewhere in this collection of statistics.

Mr. Cassidy: Basically the only place you can save money is in staff. Is that correct?

Mr. Hayes: The kinds of dollars that we are talking about cannot be picked up by savings in equipment and supplies.

Mr. Cassidy: If you were to reduce your number of employees, that means then that your ratio of health-care workers, nurses and RNAs and support staff and so on, to patients is going to drop very sharply below the provincial average. Is that right?



Mr. Hayes: We are below the provincial average now, Mr. Cassidy.

Mr. Cassidy: But it will go even further below the provincial average. Is that right?

Mr. Hayes: I really can't give you an off-the-cuff answer to that. I would have to sit down and work that out.

Mr. Cassidy: I don't want to be hostile on this, I am just—

Mr. Hayes: It's presumably true, yes.

Mr. Cassidy: Yes. Right now you are running about 75 per cent of capacity. What does it mean in additional costs, the fact that you have, according to the ministry's calculations, 15 or 20 per cent of your beds spare? What are the additional costs of having those beds, as opposed to not having them?

Mr. Hayes: There are no fixed-cost increments, because the fixed costs are handled at the 75 per cent occupancy level. We have incremental costs, or, if you like, variable costs that occur as the clientele increases. We may have to put spare staff on.

Mr. Cassidy: But just for having those beds empty, what is the cost of having those beds empty?

Mr. Hayes: There is no cost.

Mr. Cassidy: There is no cost at all?

Mr. Hayes: No. We have to heat, we have to light and we have to clean the place, sir.

Mr. Cassidy: The ministry says you should save \$168,000, but you are saying that in fact there is no cost which you save by shutting down those beds. Is that correct?

Mr. Hayes: We can save only staff costs. The shutting down of a wing, for example, will not reduce the fixed costs. If we were to go to a 50-bed capacity, for example, and if we were to staff at 75 per cent of that 50-bed capacity, then there would be substantial savings in terms of the staff members. We are looking at between 10 and 15 people at about \$14,000 apiece.

Mr. Cassidy: That would mean a very sharp reduction in terms of health care in Wingham, an area of the province where health needs have been relatively stable for a long period of time.

Mr. Hayes: We would have to reduce the number of admissions by one quarter to accommodate that, sir.

Mr. Cassidy: I see. Perhaps I could direct these questions to Dr. Dyer then. In the first place, they say there are no staff costs that will be saved by reducing the 14 beds proposed by the ministry, since they already staff at a level of capacity which equals the degree to which their beds are filled. Perhaps

you could identify the savings that they should be expected to achieve in order to make up that \$168,000?

Dr. Dyer: I think Mr. Hayes actually did say that they would save staffing costs by closing down beds. Those staffing costs are what we identify as variable costs, and this year the average calculated was \$12,000. The actual per diem costs in that hospital are \$120 a day to operate their active-treatment beds. That's the total cost, of which a little more than 10 per cent is the variable cost, the staffing cost. So if they do shut down the beds and do not staff those beds they do save those staffing costs, and that would be, as Mr. Hayes has calculated, about \$14,000 a bed.

Mr. Cassidy: I am sorry, that is not correct.

Dr. Dyer: That's what Mr. Hayes said.

Mr. Cassidy: I asked what the excess cost of having those additional beds was; he said, there is no extra cost because they have to heat and light the building anyway. I turned it around and said: "What are the savings if you eliminate those beds?" and he said: "There is no saving, because there is no staff currently attached to those beds that are deemed to be excess." Perhaps you could clarify it. He is a capable administrator, but obviously you have some other idea of how the Wingham Hospital should be run.

Dr. Dyer: Yes, if they close down the beds, Mr. Chairman, they do not save the fixed costs, we agree. That's the difference between \$12,000 per bed per year and the \$120 a day. The fixed costs would not be saved because the heat, light and water still has to go on for the plant. But by shutting down beds and not staffing them you certainly do save the amount of money that you would pay to staff that particular bed. It works out across the province to be approximately one staff per bed, on the average; the staffing cost varies between about \$8,000 and somewhere around \$30,000, depending on the hospital. The amount we struck this year as an average was \$12,000. That amount of money—and maybe Mr. Hayes can straighten it out for his hospital—would indeed be saved if those hospital beds were not staffed.

Mr. Riddell: They are not staffed. He said they're not staffed now.

Dr. Dyer: But they are staffed. The beds are staffed or else they would be shut down. If they're not staffed, then they're not in operation.

Mr. Cassidy: I visited the Wingham and District Hospital, and my understanding is that if you have an accident which suddenly brings in five, six or seven people and raises

you above 80 per cent of capacity, you pull in part-timers who are on call for those kinds of needs.

**Mr. Hayes:** That's correct.

**Mr. Cassidy:** But if there's no such need, then you don't staff the beds.

**Mr. Hayes:** That's correct.

**Mr. Cassidy:** Dr. Dyer says you are now paying to staff unused beds. Is that correct?

**Mr. Hayes:** We're into a difference in semantics here, I believe. What Dr. Dyer is talking about is the money impact of closing 14 beds. He is quite correct in saying that, in closing those 14 beds, we will see some savings in terms of salary dollars, because we will have to lay off 15 people, or about one person per bed.

In terms of the staffing of the hospital, hospitals do not staff at one per bed; they staff closer to two per bed. We staff at about 1.8 per bed in our hospital, and this takes in all the people, including myself, on the staff of the hospital.

There is one other item that I think should be considered. The \$120 a day that was discussed is the gross figure; the net ministry liability at our hospital is about \$102.

**Mr. Cassidy:** Particularly in view of the fact that the intensity of the illness of the people occupying the beds will tend to increase each time you crank down the number of beds, can you maintain the quality of care to the people in your hospital if you reduce the number of staff by 15, as the ministry is proposing?

**Mr. Hayes:** We don't think so.

**Mr. Cassidy:** I'd like to ask about promises made by the ministry back in April, when there were visits by this hospital board to Toronto and then, I believe, a visit by Dr. Dyer to Wingham. Is my understanding correct that there was a promise that the ministry was not going to cut any beds in the Wingham hospital?

**Mr. Hodgins:** Possibly I could answer that, Mr. Chairman. At the time of our meeting with the ministry it was suggested that we maintain our beds in a swinging bed count. It was determined that there was some need at times for more chronic beds, and at other times for more active-treatment beds. It was our understanding that our bed count could be maintained and possibly let the bed count actually swing between chronic and active-treatment beds; that was the understanding we came away with.

**Mr. Cassidy:** When Dr. Dyer came to visit the hospital, did his interpretation differ

from what the minister had promised you in Toronto?

**Mr. Hodgins:** When Dr. Dyer came to Wingham there was a definite amount of chronic beds that could be used from that 14 reduction; it was definitely set at seven. There was nothing talked about in terms of swinging bed count; that idea had been dispensed with entirely.

**Mr. Cassidy:** Dr. Dyer is quoted as saying that he'd never heard of floating beds. Was he not present at the meeting with the minister where that concept was discussed?

**Mr. Hodgins:** The first I heard of it was at the meeting, and it was the minister's own words that it was a swinging bed count. He used the term "swinging," and that was the first I heard of it.

[4:45]

**Dr. Dyer:** Mr. Chairman, I think what the minister was stating when they met with him was that it's perfectly acceptable to the ministry, within the bed allocation, for a hospital to use beds alternatively for active or chronic, as it applies. Generally, of course, in their case they've got 18 beds approved for chronic and they have something in the order of 82 beds operating for active. As a matter of fact, within an allocation their own statistics that they submitted to us showed that they had seven of those active treatment beds, on the average, occupied by chronic patients. So, in a sense, they were using them for alternate needs, and we have no objections to that, within the bed allocation.

The problem in the concept was they wanted a number of beds identified above the bed allocation. That was the part that the minister did not approve of. As a matter of fact, in the minister's letter to Mr. Hodgins he says: "The Ministry of Health has reviewed the documentation you submitted concerning the chronic care requirements and is prepared to allow the conversion of seven active treatment beds to chronic care beds. This is conditional that a definite chronic care program be developed by the hospital and submitted to the Ministry of Health prior to the beginning of the fiscal year 1980-81."

In other words, they could institute that right away, but we'd want a chronic program developed before next year. "The concept proposed regarding swing beds is not an acceptable alternative for consideration at this time." That was a letter to the chairman from the minister.

**Mr. Cassidy:** With respect, Dr. Dyer, you have just told us that the ministry would not mind if some beds were moved from chronic



to active or active to chronic, as needs require, but the minister's letter unequivocally says the opposite. It says that the concept of swing beds, which is what that means, is not acceptable at this time.

**Dr. Dyer:** We don't have that kind of a designation. We have active beds and chronic beds and extended care beds. There isn't such a thing in the concept of beds as a swing bed, unless it's something in the back yard.

**Mr. Cassidy:** How is a group of people who've worked for half a century to build up the funds to have a fine hospital in a community like Wingham to cope when they come down and talk to the people in the Ministry of Health and they find one answer one day and another answer the other day and a third answer the third day? Their heads are left spinning, and I don't blame them for having their heads spinning, because first it's black, first it's white and then they're told they can have something and then they're told they can't.

Do you understand? Does the ministry understand the kind of anger that exists in a community like Wingham when they go back with promises and then are told weeks later that those promises are not, in fact, to be implemented; when the minister says you can have swing beds and then writes a letter to follow up and says you can't?

**Dr. Dyer:** I think there's a misunderstanding here, Mr. Chairman, and that is, the minister did not deny they couldn't have alternate uses of beds as they require them. This is a principle that's followed in many smaller hospitals. What he was referring to was some additional beds. If you have 3.5, or at this time four, beds per thousand as the active treatment bed guideline, then we don't have a number above that, a number of so-called swing beds; but if they want to, within the number of beds within that guideline, alternate the use or use them as they see fit, that's perfectly acceptable within their global budget. Every hospital does it.

I don't think there is, from the point of view of the ministry and the administration, a misunderstanding of how you can use the beds that are allocated to you. What they mistake is that there's some other designation that you can add on the top. We have active treatment beds and we do allow, for example, an addition to that of psychiatric beds that's above the ratio. We do allow, as an example, chronic beds above the ratio and we do allow rehabilitation beds above the ratio. But we haven't got a designation of swing beds above the ratio.

**Mr. Cassidy:** I'd like to ask Mr. Hayes or Mr. Hodgins, as a result of your discussions with the ministry, originally the Wingham Hospital was to have a zero per cent increase in budget this current fiscal year with the provision of seven chronic beds, what does that mean in financial terms for the Wingham Hospital?

**Mr. Hayes:** Through you, Mr. Chairman, \$38,000.

**Mr. Cassidy:** That amounts to about \$5,500 per bed or approximately \$16 per day per bed. What's your cost of providing chronic care in the chronic beds that you now have, the 18-bed unit?

**Mr. Hayes:** Our cost for chronic care is exactly the same as our cost for active care, Mr. Cassidy. We're on a melded rate, so it doesn't make any difference whether we designate them chronic, active, convalescent or psychiatric, we still only get the same amount of money.

**Dr. Dyer** has said our figure was \$120 gross for last year; and it's somewhere in that neighbourhood again for this year. Perhaps I can clear up a couple of misconceptions. First of all, there has been no agreement by the Ministry of Health that there is a guideline on psychiatric beds. Secondly, there has been no agreement by the Ministry of Health that there's been an increase offered in terms of chronic beds. Neither of these figures apply to us. Thirdly, the seven bed average, above and beyond our current 18 chronic beds, is not true. The maximum number of beds we were able to identify as true chronic patient beds was seven. The average was about 20. What we have, in effect, are active treatment patients in active treatment beds.

**Mr. Cassidy:** If I understand, that's something over \$100 a day for those patients. The ministry is offering you the equivalent of about \$16 a day through the additional funding of \$38,000. Is that correct, when you relate it to those seven beds?

**Mr. Hayes:** I suppose if one tries to tie it to those seven beds, you could put it that way.

**Mr. Ramsay:** I should have followed this up at the time, but I didn't understand the expression. Now it's come up again: a melded rate. I understand there is a rate for active beds and a rate for chronic beds and this is figured into your overall global budget; but you talk about a melded rate, which is something that is completely new to me. Could you or Dr. Dyer elaborate on what a melded rate is?

**Mr. Hayes:** I can answer from our point of view, Mr. Ramsay. For up to 20 chronic



beds we are funded at the same rate we are funded for an active-treatment bed. The active-treatment costs are reduced, in effect, because of that.

**Mr. Ramsay:** Is this customary in hospitals your size across the province?

**Mr. Hayes:** It is.

**Dr. Dyer:** Mr. Chairman, I think the melded rate is a term that's bandied around. The fact is the hospital is provided with a global budget and they operate the total number of beds out of that globe. It's very hard to assess a particular rate to a particular bed, obviously. We express amounts of money for active beds and for chronic beds; and by and large across the province it's the overall average. For example, for an active bed in an active-treatment hospital, it's about \$150 a day. In the overall average, the cost of operating a chronic bed in a chronic program is about \$80 a day. I must say this hospital does not have a chronic program, so perhaps that's why the bed rate is higher in their chronic unit. I think that's a problem they should sort out.

While dwelling on that question, I think there needs to be some straightening of the record. Maybe I can ask Mr. Hayes about that, if I might, Mr. Chairman. He inferred there would be only \$38,000 returned if they reinstated seven beds. The reason for that is because they already have an adjustment of \$33,000 that was not constrained. If you take \$12,000 per bed, times the 14 beds, you come up with \$168,000. Because that took them below the last year's net ministry liability, an adjustment was made and \$33,000 was reinstated; so in fact they were only constrained \$135,000. In recalculating, we would simply adjust their budget back again to bring them back to a constraint of \$84,000, or seven beds. It seemed to me that Mr. Hayes said, or implied at least, the ministry had not undertaken to reinstate that amount of money as a result of converting active beds to chronic beds, but the commitment is in the minister's letter.

**Mr. Chairman:** Mr. Cassidy.

**Mr. Cassidy:** I'm nearing an end here.

**Dr. Dyer:** Can I pass it to Mr. Breough?

**Mr. Cassidy:** If we take the figures that Dr. Dyer has offered, that chronic care costs about \$80 a day—for the sake of argument perhaps Dr. Dyer could explain—in adding the seven beds back for the Wingham hospital, we now have a couple of figures in terms of what that means in financial terms for the hospital. It's either \$16 a day, if you take it that the hospital is getting \$38,000 back; or to take Dr. Dyer's figures it amounts

to about \$70,000, which works out to about \$30 per day. Now how is the hospital to add back those seven chronic beds which cost, let's say \$80 a day to provide, if the provision in the ministry's budget is only \$16 a day or \$30 a day?

**Dr. Dyer:** Mr. Chairman, because of the adjustment that was taking place here, and the hospital was only constrained \$135,000, in a sense they get constrained less than \$10,000 a bed—in a sense. So therefore in returning that would be the figure that would be returned if they converted to seven beds.

**Mr. Breough:** Dr. Dyer, we would never buy a used car from you.

**Mr. Cassidy:** Is it fair to assume, Mr. Chairman—this is to Dr. Dyer as well—that when the minister came back and told us about programs to put chronic beds in place of the active-treatment beds that were being cut, that what the government is doing is cutting beds at a high rate, but that the chronic beds that are being restored, where they are being restored, are being restored at a very low per diem rate?

**Dr. Dyer:** No, that is not the case. In the examples I cited yesterday, for Timmins for example, the exact amount was restored, the \$12,000 per bed that was constrained was restored for those beds that were converted back. We are doing that in every case, in spite of the fact that in the long run it will probably cost less to operate that chronic bed on a variable cost, so it will probably be less than \$12,000. But that amount of money is being reinstated in every case. The same thing would apply in the Wingham hospital.

**Mr. Cassidy:** This is to Dr. Dyer as well. This hospital, the Wingham hospital, is being pushed to the wall in terms of what is happening right now. Perhaps you could say, Mr. Hodgins, what are the alternatives now facing the board in terms of the next steps that the board intends to take if the ministry does not carry out its promise to ensure there are no beds cuts?

**Mr. Hodgins:** I guess there are two or three prominent alternatives that we might take. One is to accept this token of seven chronic beds at their method of funding, accept that and say nothing. The next method is to possibly start a menu billing, whereby we bill the patients for the services. From there we bill the government for the services we provide for the patients. Possibly this will mean opting out of the organization. If they don't pay for the billing that we do perhaps we will have to battle it out in court.

**Mr. Cassidy:** As I understand it, menu billing means that you effectively opt out of the

Ministry of Health's hospital financing, bill patients, and then the patients would be expected to get the cost of their hospital care from OHIP.

**Mr. Hodgins:** Yes, that would be basically it.

**Mr. Cassidy:** What is the position about that, Dr. Dyer? Obviously, I don't think anybody can look with equanimity on that particular proposal.

**Mr. Hodgins:** We are not in favour of that.

**Mr. Cassidy:** What did you say?

**Mr. Hodgins:** We are not in favour of going that route. We would certainly like to try and negotiate. As Dr. Dyer said in his letter, we'd like to work together to solve our problems. We are willing to work out any alternatives to try to solve our particular problem. That was set out in Dr. Dyer's letter, sent to me on May 17, along with the various other items regarding the seven beds for chronic care. That's the route we would like to take.

**Mr. Cassidy:** You prefer to negotiate, is that right?

**Mr. Hodgins:** That's why we are here today.

**Mr. Cassidy:** Mr. Chairman, to Dr. Dyer: Is it the intention of the Ministry of Health to carry on this program of privatization of hospital care to the point where many hospitals across the province will feel compelled to bill patients directly because they can't get adequate funding to carry out a decent service through the Ministry of Health's regular programs?

[5:00]

**Dr. Dyer:** Mr. Chairman, it is certainly not the intention of the Ministry of Health to resort to privatization. As a matter of fact we continually have discouraged this hospital from entertaining that view. In the letter from the minister, or at least the letter from myself to the chairman, I said—and if I might quote it;

"I also feel that the advice you received in terms of the possibility of opting out of OHIP is counterproductive. In order to solve the particular problems being encountered by your community, any precipitant action of this nature would place the ministry in the position of having no choice but to contest the issue and take whatever steps necessary to protect the integrity and the accessibility of the health-care system."

It is the view of the ministry that, first of all, there is a section, Mr. Chairman, section 39 of the Health Insurance Act, that states—and I apologize for not having the exact

words—but it states that, "an insured patient shall not be charged any amount for an insured service in a hospital". So it's the position of the Ministry of Health that an attempt to do that would be contrary to that regulation.

I understand that the hospital has some feeling about that regulation, but that currently is a regulation. We are holding that that regulation is the authority under which we act. So we haven't any way of relating to a chart system, nor do we want to in any event. We feel there are many other ways for this hospital and other hospitals to cope.

One of them is to recognize that this hospital is operating now at 5.7 beds per 1,000. As Mr. Breaugh knows, the Oshawa hospital is at 3.5, that's the comparison. The services provided there in day surgery and so on are quite applicable. This hospital has been offered, on the basis of their data, a reinstatement of funds for active beds converted to chronic care. It has also been suggested to them, and other hospitals, that they engage management consultants, because we feel the balance they are looking at is another \$84,000. There is every possibility that a management consultant would certainly identify that and more, as they have around the province. Of the management consultant studies that have been undertaken, the results have always been upwards of \$200,000 for a hospital of this size.

Therefore, I'll be encouraged if they are going to undertake something of that nature. I think that would help them to sort out the problems of trying to fund the hospital adequately.

**Mr. Cassidy:** Mr. Chairman, I have to leave now for a radio broadcast. I want to say to the deputy minister that what is being done is that the ministry has indicated it will contest in court this possible action by the hospital in Wingham. But there is no such action by the minister to contest in court when doctors choose to opt out and to double-bill or extra-bill patients for services which are insured, but not to the rate that the doctors wish to charge.

I wish these officials of the Ministry of Health could take back to the minister the feeling of anger which I certainly experienced when I talked to the people in Wingham a few days ago. Their feeling of outrage in light of providing the service, of being one of the most efficient and economical hospitals of its size in the entire province, then to get comments from the Ministry of Health such as the one we have just heard saying: "Look, everybody can save \$200,000 or \$300,000; there is really no problem at all".



I know that this hospital, like others, is waiting for the other shoe to drop and wondering what on earth they do next year and the year after if there are a further 17 beds to be cut in the Wingham hospital on top of the cuts that perhaps are being imposed this year.

**Mr. Chairman:** I should tell the committee we are really going to have to move along. I have Mr. Sweeney, Mr. Riddell, Mr. O'Neil, and Mr. Breagh on the list. We do have a vote in the House about 5.50. So I suggest to the members that we move along. Mr. Sweeney.

**Mr. Sweeney:** Given that comment, Mr. Chairman, I'll just ask one basic question. Could either of you gentlemen help me to understand how the figure of 51 active beds, suggested by the ministry, was arrived at? I ask the question based on this: I notice that at present you have 82 active beds and you have a use of approximately 76 per cent. of those. My old arithmetic, old maths, says that comes out to about 62 beds that are in use almost all the time. If we throw in the other 10-bed cushion I've heard bandied around here, that brings us up to 72.

In other words, even using some kind of logical, mathematical calculation, I can see how a figure of 72 could be arrived at. I don't necessarily agree with it, but I can see how you could arrive at it. I'm completely at a loss to know where the figure of 51 comes from. Can either of you explain out of what clouds such a figure comes? What's the rationale? What's the calculation? What's the basis? What are the criteria?

**Mr. Hayes:** Mr. Chairman, the calculation is based on a referral population and a 3.5 guideline. The referral population is derived from actual cases. The 3.5 guideline comes from God.

**Mr. Sweeney:** Excuse me, Mr. Hayes. You indicated that your service area consists of a population of about 30,000.

**Mr. Hayes:** That's correct, sir.

**Mr. Sweeney:** Okay. If I use 3.5 there, I come up with 105.

**Mr. Hayes:** We do too, sir.

**Mr. Sweeney:** Okay. Then somebody else quoted a figure of 13,000. I don't know where that one came from, but the figure was used. If we use that one, then we've got 45. In other words, nothing fits.

**Mr. Hayes:** The 13,500 is referral population. That's referral population as derived, using the guidelines.

**Mr. Sweeney:** But surely the 30,000 people in your service area are the ones who at

any point in time you have to be prepared to offer service to.

**Mr. Hayes:** That would appear logical to us.

**Mr. Sweeney:** In other words, what I hear you telling me is that, in your judgement, there really isn't any logical rationale to that figure of 51?

**Mr. Hayes:** That's correct, sir.

**Mr. Sweeney:** No wonder you're confused.

**Mr. Chairman:** Mr. Riddell, and then Mr. O'Neil.

**Mr. Riddell:** I'll try to be brief, Mr. Chairman. I know you people, or the members of the Wingham and District Hospital board, met with the minister early in April and came away with certain commitments. After you left, the members of the Goderich hospital board went in, and they came away with certain commitments.

We've learned from the questioning of Mr. Cassidy that there has definitely been a different interpretation put on this swinging chronic bed situation by the ministry officials. As I indicated in my comments last night, there certainly has been a different interpretation put on the minister's commitments by his officials on such things as the restoration of a \$60,000 penalty to the budget. The ministry officials are trying to throw some hookers into this, and I'm hoping the representatives of the board here today will talk about this.

I want to ask you people, have you encountered any other different interpretations that are being put on what the minister actually told you when you met with him and what the ministry officials told you when they later met with the board, apart from the swinging chronic bed situation?

**Mr. Hayes:** Mr. Chairman, perhaps I can answer part of that question and Mr. Hodgins the rest.

**Dr. Dyer** has been quoted in the newspaper as saying the number of beds has no relationship to anything; what's really being talked about is dollars. I think perhaps that's where we're at, really. At the meeting, at least at one point during that meeting, it was stated that it really didn't matter how many beds we had or how they were utilized; we weren't getting any more money anyway.

We did discuss the possibility of creating a health service organization in the Wingham area, and to do that it was stated that we required capital funding to renovate the existing structure to accommodate that concept. Our hospitals were built to do what they do now, and they do it very well, that is to take care of active-treatment patients and



chronically-ill people. They were not originally built to function with large outpatient departments. Most of the smaller ones certainly do not have this capability. They are slowly being converted, but it's a slow process when capital funding is not made available through the Legislature. That was discussed.

There were actually four items. The first item was a discussion, in which we seem to have bogged down, regarding the swing beds. The second was the return of the funding; in the minister's words "up to \$168,000." The third was an agreement to explore the HSO concept. The fourth was to examine possible methodology for capital funding for the necessary renovations to create the climate for the HSO to function within. Does that answer your question?

**Mr. Riddell:** I have one final question. Maybe in the interest of time we could get the Goderich board to elaborate on this one, but we'll give the Wingham board an opportunity too. It's obvious from your brief that in your view there should definitely be a distinction between rural and urban hospitals in so far as the application of the ministry formula is concerned.

In all fairness I can say that most of the members on this committee are urban oriented, but in all due respect I'm sure they can appreciate the problems we have out in the rural ridings. Maybe you people would care to elaborate on the distinction that should be made, and the reasons there should be a distinction, between the application of that formula for rural and urban hospitals.

**Mr. Mann:** One of the first things that comes to mind is the area that is to be served. If you think of a large urban centre, where there may be more than one hospital, one has rather easy access to hospital care. The majority of our people have to travel some distance to get to hospital. The point has already been made that it's not always possible to travel great distances to a hospital. We run into that problem from time to time with our weather. If you can make it to the local Wingham hospital and then transfer is necessary because there are insufficient beds, where do you go? I'm dwelling on weather because it has already been brought up that our original meeting with the minister had to be postponed because on that day you couldn't see across the street to drive. That was in April. When that type of thing happens, it's just impossible to move people from Wingham to London. So where do these people go?

In the addendum to the brief, using some of the statistics—I can't remember them

exactly—I think Mr. Hayes has shown that with the present formula our occupancy rate would range from a high of 147 per cent—and I don't know how one can go 47 per cent over one's capacity—to 71 per cent, which we could probably handle. That was a low, the average is 122 per cent. If our average is going to be 122 per cent, where do we put those other people? If we can't move them out because of weather—and this is one of the things in a small rural hospital—what do we do with these people?

This is one of the concerns of the people in the area. I don't speak knowledgeably on referral populations and this type of thing, but I do get concerned when I see a hospital getting smaller and smaller and services starting to drift away from a hospital, which means that one has to move to places like London to get those services. Then it doesn't make any difference what the weather's like as we still have to move to get them. The hospital gets so small it becomes no longer viable. Then what happens? A lot of the people are worried that at some point down the road that hospital is going to be closed because of cutback after cutback. Someone eventually comes along and says it is no longer viable.

We serve an area in our part of south-western Ontario that doesn't overlap, really, with any other hospital. Some of you may have the brief before you. There's a map showing the service areas of different hospitals. In a 16-kilometre radius we're the only hospital. We don't overlap with any other hospital. The closest hospital is probably more than 25 miles away. That's a fair way to travel and you can imagine people saying: "What do I do with a sick child when I can't get a bed here; and what do I do with somebody who is injured when I can't get a bed here?" This is the type of concern they have.

[5:15]

Other things in the brief, if you care to look through, are references to the high percentage of our population which travels daily by school bus; the large number of people who move through our area either on highway 86 or highway 4 to go to the vacation areas. There is very heavy traffic through the summer; accidents occur and they have to be dealt with locally. If we have the space, fine, but what happens if we don't have the space; again getting back to your question of where this number 51 comes from. All of these things contribute to some concern. I don't know whether that answers all of the concerns, but I know those are some of the major ones.

Mr. Riddell: Not to say what would happen if we had a mining disaster, say, in Goderich where we have the Goderich salt mines. I am sure you don't have much mining taking place in your large urban centres. There is also the high proportion of senior citizens. We could go on and on and talk about the reasons there has to be a distinction between the two different types of hospitals. However I will let it go at that.

Mr. O'Neil: I wonder if I could ask a question of Dr. Dyer. After listening to what's been said here today, and hearing about the comments and previous correspondence you have had with the board, reviewing the problems that exist, as well as things Mr. Riddell and other members have mentioned—and I would rather be asking this of the Minister of Health who, I think, should have been here rather than you—is your ministry prepared to change its mind on the allocation of the bed closures and the amount of money that has been given to this board?

Dr. Dyer: Mr. Chairman, the ministry did not order bed closures. I think that has to be clarified for the record. The ministry identified numbers of beds surplus to the standard. At the same time, it also identified funds associated with that but they weren't ordering bed closures. That's the first thing I think we need to clarify.

Mr. O'Neil: Then, maybe we should question the standard or the 3.5 per cent in this case we are talking about—you have one figure on the surrounding population and they have another. There's something wrong here.

Dr. Dyer: Mr. Chairman, the number of beds in a locality, that is the supply of beds, is always filled if they are there. That's a principle that happens but there are a number of communities, such as Bracebridge, as isolated as Wingham that have 3.5 beds per thousand and they operate efficiently. Their morbidity rate and their mortality rate in that area is no different than it is in Wingham, so the supply of beds has not been shown to be relevant in that regard. We are trying to strike uniform standards across the province and I would say that the people in Bracebridge are entitled to the same kind of health care as anywhere else.

Your question was what are we prepared to do? There were a number of things we are prepared to do to help them sort out the problems there outlined in a letter to the chairman and perhaps he might read those. One of the areas that I find a little discouraging is that Mr. Hayes said that we are not prepared to consider an HSO but in section

three of that letter it says definitely, and I will quote it to you: "The Ministry of Health recognizes the interest of your community in the holistic concept of health care and is willing to examine and review the development of an HSO." If that isn't a firm commitment to examine and review that and develop it if they wish, I don't know what is.

He also made the statement that somebody—and I am not sure whether it was aimed at myself—stated at a meeting that they were not getting any more money anyway. That, again, simply isn't true because we have made several commitments that we would restore at least \$84,000 on the basis of the study they submitted. We have also suggested that if they wish to examine further their chronic-care needs, we will look at that. We have also promised them we will fund a study in the area to examine the extended-care needs because that's a problem we face there. Money is being spent in the area and there is money being offered to the hospital, so it's wrong to have on the record that the ministry is not prepared to provide any funds for them.

Mr. O'Neil: There are a lot of cases. You are saying to them, "Do a study and bring in a bunch of consultants." In the meantime, you are holding this threat over their heads that you are going to close beds because of lack of money to run the hospital properly, cut back staff and all of these things.

They have shown to us today there is something wrong if you take that 3.5 per cent and try to apply it to this hospital, using your figures as far as population is concerned. There is something wrong either with your figures or theirs. I think there should be some consideration given by the minister and ministry staff to having another look at these population figures. I think something should be done to assure them they are going to find a solution which will be of some assistance to them and not hold the threat over their heads that you will do the studies when, after all, nothing may happen in the end.

Mr. Kennedy: That's an exaggeration.

Mr. Turner: We're working on the same basis your hospital is working on.

Mr. O'Neil: There are circumstances in every area that are different.

Mr. Chairman: I should alert the members to the fact we still have a hospital board from whom we have to hear. I am really getting concerned about the time. Have you finished, Mr. O'Neil? Mr. Breaugh, and then



Mr. Kennedy. If we could wind it up very quickly, I would greatly appreciate it.

**Mr. Breagh:** In the May 10 edition of the *Record*, the local newspaper, you are quoted, Mr. Hayes, as saying, "I have been had. It now appears that none of these promises appear to be true." Do you still feel that way?

**Mr. Hayes:** I do, Mr. Breagh. Perhaps I can illustrate why. I would like to continue reading in the paragraph Dr. Dyer just read from his letter.

We talked about the development of the Health Services Organization in paragraph three: "In order to give further consideration to the concept, it will be necessary to submit the size and age of the population being served by your community physicians. The roster size of the physicians is necessary in order to determine the amount of funding that would be available to develop an HSO."

The sense of that is that at the meeting in Wingham we were told the capped figures for a HSO would be our present funding plus the amount of money that was being paid to physicians; and any savings within that would come from the physicians admitting fewer people to hospital. Quite naturally, the physicians were a little uptight about that one.

**Mr. Breagh:** A second quick question, then, dealing with the letter from Dr. Dyer to Mr. Hodgins. In one of the closing paragraphs, it says:

"I regret that you or your board members were apparently being provided with misleading and inaccurate information on the policies and position of the Ministry of Health." Do you know what the hell that means?

**Mr. Hodgins:** No, I don't.

**Mr. Breagh:** Neither do I. Let me just close with one comment, Mr. Chairman. I believe these people have been had. I believe I have seen reversals in position by ministry staff here this afternoon, let alone from the ministry's office, in the formal letter from the deputy minister to the board itself. It strikes me as readily apparent that these people are caught in a squeeze on a set of theoretical standards that don't fit, and they are either going to get squeezed into those standards, or go out of business completely. I think that's insane.

**Mr. Kennedy:** I just have one question. Mr. Hodgins, you described the shift of seven beds from active to chronic, as I understood you to say—and as I understand is part of the proposal—as token. Yesterday the minister, in reading a statement here, said there is

a survey that shows there could be a shift of something like 10 per cent, based on the results of survey in hospitals over the area generally. Does this proposal concern you? Don't you want these seven beds? What are your comments with respect to that when you listed it as a token?

**Mr. Hodgins:** Seven beds have been returned as chronic beds. Our study determined that at the very maximum we could use only seven chronic beds at any time. That's the most that ever showed up. The norm was we could use two more chronic beds. The average was two more chronic beds, but seven was the very maximum that showed up on the survey that would ever be needed at any one time.

**Mr. Kennedy:** Don't you feel you need the shift?

**Mr. Hodgins:** We need the active treatment beds much more severely than we do more chronic beds. We do need more chronic beds, but we don't need that many. However, we do need more active-treatment beds. That's the whole problem.

**Mr. Hayes:** Mr. Chairman, perhaps I can clarify this slightly. We have a very active placement program. When Dr. Dyer says we don't have a chronic-care program in position, I'm not quite sure what he's talking about.

We have physiotherapy and we had occupational therapy until I had to lend my occupational therapist to another hospital to cover a pregnancy. We have a discharge planning co-ordinator who runs a very active placement program for chronic and active patients under home-care programs. We only have an active home-care program. We don't have a chronic home-care program in our area.

We get first choice of three nursing homes around us because they're very close to us: Brookhaven in Wingham proper, the Brussels nursing home and the Lucknow nursing home. We get people into Huronview, which is the home for the aged in Clinton, as quickly and as often as we can, but they're pretty full too.

We try to get people back into their own homes and in some kind of a support condition where we can. I'm not sure what other things we can do from a chronic home-care point of view. We have two gerontologists consulting at staff, Drs. Cape and Robinson from the hospital in London. One begins to wonder what more can be accomplished.

What we demonstrated is that we don't need chronic beds. We need active-treatment



beds for patients who come to us for short, episodic incidences and then are sent home again.

**Mr. Kennedy:** Perhaps this upcoming study will be one of the terms of reference. I presume it will cover the whole field of health delivery service in the area.

**Mr. Hayes:** One would hope that that is true.

**Mr. Kennedy:** You don't have a district health council?

**Mr. Hayes:** We do not.

**Mr. Kennedy:** Have you ever considered this?

**Mr. Hayes:** It was turned down because it was considered to be an added expense in the district.

**Mr. Kennedy:** If there were one, how broad would it be? Your county only or two counties?

**Mr. Hayes:** The steering committee was from Huron and Perth counties. Both counties turned it down.

**Mr. Kennedy:** How long ago was that?

**Mr. Hayes:** About a year or a year and a half ago.

**Mr. Kennedy:** We had a two-county study ourselves a couple of years ago and we went along with the district health council which, I might say, was resisted at first. Opinion was divided but it seems to be being accepted and it is doing a good job. They're in the throes of expansion in Mississauga.

**Mr. Chairman:** Thank you very much, gentlemen. We certainly do appreciate your coming down and sharing your views with the committee. I would like to call the Goderich Hospital Board: Mr. Taylor, Dr. Conlon, Mrs. Zurbrigg and Mrs. Berry. Mrs. Berry is the chairman of the board. Dr. Conlon is on the medical staff and Mr. Taylor is the administrator.

**Mr. O'Neil:** Mr. Chairman, may I ask how much time is allotted to this board?

**Mr. Chairman:** To be fair, Mr. O'Neil I believe there is a vote at 5:45 p.m. I want to be absolutely fair to the people from Goderich. They've come a long way and I want to give them as much time as we possibly can. I'm suggesting to the committee that we carry on during the vote with one member present from each party. In essence, that means pairing. I'm prepared to go on as long as we have to in order to give the Goderich people an adequate hearing.

**Mr. O'Neil:** Mr. Chairman, some of us have taken some interest in the vote that is going

on in the Legislature. Is there any chance we could attend for the vote and reconvene here after?

**Mr. Chairman:** Yes, there is. But I think that if one member from each party stayed here and we carried on, those who would vote could then come back down to the committee and could carry on. Is that satisfactory? I think that's only being fair to the Goderich people. Fine. Thank you then. We'll carry on.

**Mrs. Berry,** do you have some opening comments? First of all, welcome to our committee. I'm sorry that there's been some delay. We apologize for that but I'm sure you know how these things go.

[5:30]

**Mrs. Berry:** Thank you very much. We appreciate the opportunity to be here. We have copies of the brief we submitted to the ministry.

Our situation, while similar to Wingham's in many respects, differs in other respects. We operate a psychiatric unit of 20 beds that services all of Huron county. There are staff psychiatrists and psychologists in this unit; they travel to Wingham to provide this service, and that puts our costs up. The ministry has compared our costs with those of Wingham, and we feel this is the major reason for the increase.

We are in agreement with the ministry, which has often suggested that this unit should be moved into our general hospital. We are quite willing to do this. We figured we could do this with the savings we might generate by having a firm of management consultants do a study as was suggested by the ministry. At our board meeting last night, we passed a motion to have a firm of consultants do a study.

I just received the letter from the minister yesterday, in reply to my letter of more than a month ago, reiterating the facts we had agreed upon at the meeting. In essence, the majority of things are as we understood them. The exception is that the minister said to us that he would return \$60,000 to our base budget to pay for the 10 extra chronic beds he was allowing us to have. In his letter, he informs us that the ministry will pay for these chronic beds but the money will come out of the savings generated by the management consultants.

Our concern is that we're going to lose the \$60,000 out of our basic budget. There was no doubt that we needed the extra 10 chronic beds. We have only 10 chronic beds allotted to us up to this time. The extra 10 chronic patients were in active beds because there was no place else for them to

go. If the ministry took the formula that we had 20 chronic beds, then we wouldn't have any penalty at all; it wouldn't be over their formula. Our contention is that the ministry should rework the formula allowing 20 chronic beds so that there wouldn't be any deficit or overage of beds and we would still have our \$60,000.

Being a tourist town, we have many extra patients in the summertime. Being a small-town hospital, we cannot turn patients away as they can in a referral hospital; you can go there by referral and there can be a waiting list. There's no such thing in a small hospital. If somebody is sick, that person has to go into hospital; we cannot turn him away. We also have a list of patients waiting to get into these referral hospitals; they can't get in because their number hasn't come up yet. We get calls back from the hospitals in London wanting the patients to come back to us, but we don't have the beds for them to come back to.

The ministry allowed us a float of 10 extra beds for our peak periods. We have very high and low censuses. Since the time that the ministry allowed these extra 10 beds, we have been running at a 95 per cent occupancy rate which is my understanding, is above what the Ontario Hospital Association considers a safe level.

We have brought our beds down to four beds which is where we're supposed to be, but we feel that we cannot in all honesty come down to 3.5. We feel we have reached the point where we can't reduce any more and still have a viable operation. It's all very well to say, "You can cut out some services." But if we cut out different services, then we're soon going to lose our doctors. Doctors won't stay in a town where they can't operate in their profession to the best of their ability.

There has been a change in our referral pattern, which the ministry recognizes, and it is willing to look into that portion of it.

Our main concern at this time is the letter that we got from the ministry and the result of this \$60,000; there is no mention of building that back in again, but rather taking it out of any savings we have from the study by the management consultants. I don't think I have anything else to add.

**Mr. Breagh:** Mrs. Berry, you seem to be a very calm and rational person, and I admire you for that approach.

There seems to be a clearly definable trend here to put you out of business. You have had your hospital cut almost in half—you will have in the future. It strikes me that your requests have been put in a most reasonable

tone, and it does not strike me that they are going to bankrupt the province of Ontario.

What does concern me, though, is the effect that a hospital has on a small town in Ontario. You need certain basic requirements to have a hospital; otherwise, you are running a hotel of some kind. If you don't have those, you begin to lose your doctors, and the people in the community begin to lose faith in the hospital. How close are you to that point?

**Mrs. Berry:** That is quite true. We must have services. We are quite proud of our hospital. We have a good hospital and provide good services. But the minute we start cutting the services, we are going to lose our doctors; they won't stay.

The ministry seems to feel that everybody over 65 who comes into hospital is a chronic patient. We in Huron county have a higher rate of people over 65 than the average for the province. It is also a known fact that these elderly people require more treatment and active beds than does the ordinary age group in a population.

**Mr. Breagh:** Do you have any hope that this conference on small hospitals, which has suddenly appeared, will offer much in the way of reconciling your problems with the theories of the ministry?

**Mrs. Berry:** That all depends on whether the ministry is willing to listen as well as to talk.

**Mr. Breagh:** On their track record so far, do you think they will?

**Mrs. Berry:** In all fairness to the ministry, they certainly did help us considerably when we came down. It is just in the one area that we have questions. They did grant us the extra 10 chronic beds; we need the funding for them, though. They did allow us the extra float of 10 beds; of course, they allowed us that provided it didn't cost them any more money.

**Mr. Kennedy:** Could I interject with a supplementary? Do you feel you need the 10 chronic beds?

**Mrs. Berry:** Oh, definitely.

**Mr. Kennedy:** The previous witnesses don't feel that. They said they would be more interested in active beds. We also heard earlier that there is the swing situation—not designated as such—if the need arises. But you are happy with—

**Mrs. Berry:** I didn't say we needed more active beds. We certainly need the extra chronic beds. As far as our active beds are concerned, we have been reduced to a level where we don't feel we should be reduced



any more if we are still to have a viable operation.

**Mr. Breagh:** Could I ask you just one final question, Mrs. Berry? You people are constituted as a local hospital board. If you are like the people in the community I was born in, you probably helped to raise funds for the hospital and continue to play a reasonably large role in the operation of the hospital. The purpose of this exercise is to have local input, control and influence on the type of hospital there. The theory is that local people will understand the needs of the municipality or the community they serve and can best make the decisions about what kind of care ought to be provided. Do you feel your position as a local hospital board is tenable any more, when the rules of the game are strictly enforced by someone from outside the community?

**Mrs. Berry:** We do feel that the Ministry of Health is encroaching on the role of the hospital trustees and, if it continues to do so, we will be no longer be able to attract the high calibre of trustees that we have to date. People get frustrated when they aren't able to plan for the future because you never know from one year to the next what money you are going to get. The ministry steps in and designates how we're going to spend that money. We realize that there's only so much money and the ministry has to hold the purse strings. But when they give us the budget, that's where their responsibility should end. It's up to the local hospital boards to operate their hospital as best they can within that guideline.

**Mr. Breagh:** Are you considering any of the concepts we've discussed earlier this afternoon about giving up the ghost on ministry funding and attempting to finance the thing on your own in some way?

**Mrs. Berry:** No, we have no intention of going that route.

**Dr. Dyer:** For clarification could I ask Mrs. Berry a question? In terms of the ministry assisting you, did the ministry give you any additional funds last year?

**Mrs. Berry:** We had a deficit and the ministry picked up some of the deficit.

**Dr. Dyer:** Could you indicate how much money that was?

**Mrs. Berry:** I believe it was \$140,000.

**Dr. Dyer:** Yes.

**Mr. Breagh:** Could I ask Dr. Dyer a question since he interjected? Normally, to get to ask questions in this committee, you go out, find a constituency, and get elected—

**Mr. Chairman:** To be fair, Mr. Breagh, I had indicated to Dr. Dyer that if he wished at any time to interject on matters of clarification or information, then he could. To be fair to him, it was at my suggestion, not at his.

**Mr. Breagh:** You're being a bad boy, Mr. Chairman.

**Mr. Chairman:** You can slap my wrist. I don't consider you stepped out of line at all, Dr. Dyer.

**Dr. Dyer:** There are a couple of other points I'd like to sort out for you, Mr. Breagh, just so that we have the record straight.

**Mr. Breagh:** You hung them up for \$40,000 last year and you're letting them keep \$60,000 out of money they saved this year.

**Dr. Dyer:** The hospital did request—

**Mr. Breagh:** I understand that kind of deal.

**Dr. Dyer:** The hospital was constrained five beds this year as the surplus. It did request to have those five reinstated, plus an additional five, in chronic care, and it did provide the evidence of that. That was granted. The five were reinstated, plus an additional five, which increases the hospital size from 88 to 93 beds. That's hardly a sign of trying to reduce this hospital, I would submit.

The other thing I want to suggest is that there is perhaps some confusion on the part of the administration and the board as to the funding. The wording in the letter, which I'll read for the record, if I may, simply says: "The additional operating fund requirements for the expanded chronic unit may of course be offset in whole or in part by the operating cost savings achieved as a result of the consultants' work."

That was stated deliberately because there were only five beds reinstated. The hospital might indeed be entitled to that reinstatement of funds. That has not by any means been decided. That's part of the ongoing negotiations. There are an additional five beds, and where the funds for those additional five beds will come from has not been determined. As a result of the \$140,000 that was given to the hospital last year, part of the commitment of the hospital at that time last summer was that they would engage management consultants. Those management consultants, as I understand it, have now been engaged, as of yesterday. I would like to ask Mrs. Berry if she's prepared to indicate from the initial survey the sum of money



that those consultants have identified as a potential saving within their operation?

**Mrs. Berry:** They haven't proceeded that far. They just gave us an initial proposal to present to the board. They did intimate there would be savings though.

**Dr. Dyer:** Did they indicate in any way the size of that?

**Mrs. Berry:** I'd like to question you on your number of beds. We do not have 93 beds. We have 73.

**Dr. Dyer:** I may be wrong, but the record is 58 active, 20 chronic and 20 psychiatric.

**Mrs. Berry:** We have 43 active, 20 psychiatric, and 10—That's what we're operating at right now.

**Mr. Sweeney:** What are those figures again please?

**Mrs. Berry:** Forty-three active, 20 psychiatric—

**Dr. Dyer:** Do you mean we're not constraining those 43 beds?

**Mrs. Berry:** We're now operating the 20 chronic, but we only had 10 before.

**Dr. Dyer:** The hospital had a 10-bed cushion, and so of the 58 active beds only five beds were constrained this year. So in a sense you were funded for 53 beds—not 43—plus 20 psych, plus 20 chronic—

**Mrs. Berry:** No, only 10 chronic. We were only allowed 10 chronic at that time. It's only since the ministry visit that it was raised to 20. My contention is that if we should have been having 20, then we shouldn't have been penalized for the five.

**Dr. Dyer:** In fact, we're not penalizing for five, we're reinstating the five. That's in a sense what is being done.

**Mrs. Berry:** We haven't got that in writing.

**Mr. Breagh:** You'd better, before you proceed.

**Dr. Dyer:** In the letter of May 16, the minister says: "I am agreeable to the conversion of 10 active treatment beds to 10 chronic beds."

**Mr. Sweeney:** You can't count the 10 twice.

**Mr. Breagh:** They've been doing that all afternoon. They've been selling off my house and letting me keep half. It's great fun.

**Mrs. Berry:** Perhaps the ministry could clarify whether it is willing to give us the funds to operate those extra 10 chronic beds, or are they going to take funds out of the savings from the management consulting program?

**Dr. Dyer:** I think the minister indicated to you what we'd like to see is the size of those funds that have been identified. From our early information, we understand the savings that have been identified are fairly sizeable.

**Mr. Riddell:** How can those savings be identified when the consultant group is just starting to work?

**Dr. Dyer:** They do an initial survey, and out of that survey they identify expected savings.

**Mr. McClellan:** Are you telling us you have the figures and the hospital doesn't have them?

**Dr. Dyer:** No, I don't have the figures. I have an estimate of what they are.

**Mr. McClellan:** But the hospital doesn't have the estimate?

**Dr. Dyer:** I'm sure the administrator has the figures.

**Mr. McClellan:** You do a wonderful job over there.

**Dr. Dyer:** Do you not have the figures?

**Mr. E. Taylor:** We had thought this study was confidential between the hospital and the people we might employ to undertake the study. We have not been informed of any savings. We have discussed the potential for some savings that may be there. This does involve a major change in our physical facilities. We will require the operational savings found by the management consultants to fund that change over the ministry's incentive program of 10 years, not to fund 10 additional chronic beds.

**Mr. Chairman:** Dr. Conlan, did you want to make a comment on this point?

**Mr. O'Neil:** Could I ask first: do you have figures from the consultants? What were these figures you were mentioning?

**Dr. Dyer:** No, we have no figures. We just have—

**Mr. Riddell:** You quoted figures to me yesterday during my comments.

**Dr. Dyer:** The management consultants indicated, and they have indicated to the hospital, that there would be substantial savings—in the area of hundreds of thousands of dollars. That's the only figure—

**Mrs. Berry:** They indicated they would find savings: they didn't have any idea of the extent of the savings. Our board last night was very concerned on this point of confidentiality. Is it the hospital that's hiring the management consultants or is it the Ministry of Health? Are we dealing with them or with you?

Our point is that the management consultants may come up with proposals we feel we can't live with. Are these figures then going to be handed to the ministry and is the ministry then going to say we have to do that anyway? This is a great concern of our board. Do we have the right to say what proposals we are going to accept or not?

**Dr. Dyer:** The decision of how much of the consultants' recommendations you accept is the board's decision and what you do with the money is your decision as well.

In any of the experience we've had to date, the hospital keeps the money we have identified—and I mentioned some substantial sums yesterday—as savings from other areas. I'm only going by the kind of estimates that are given us by other hospitals. In those areas where savings have been found, the hospital has retained them.

**Mr. Breagh:** There is a question, Dr. Dyer, as to how you got this information from the consultants.

**Dr. Dyer:** We asked the consultants whether they had been engaged, because the commitment was made on the part of this hospital last year. We have the commitment in writing that they would engage consultants—

**Mr. Breagh:** That's fair.

**Dr. Dyer:**—and we have been asking them every so often, frequently throughout the year, "Have you engaged consultants yet?" We knew these consultants went in and did an initial survey. We heard that was done, so we were quite encouraged by that.

**Mr. Breagh:** Who told you that?

**Dr. Dyer:** The hospital.

**Mr. Breagh:** It was the hospital board.

**Mrs. Berry:** As a matter of fact, we had four or five consulting firms do it and it was not until last night the board decided which company we should engage. In fact, the company itself hasn't received word from us.

**Mr. Breagh:** Oh, wait a minute, Mr. Chairman. Dr. Dyer just said the consultants—and he hasn't named them yet—have already established hundreds of thousands of dollars of saving in the administration and they haven't even got the contract yet to do the work. I don't mean to suggest he is misleading the committee, but I want to tell you I have a helluva time following that one—how a consultant firm, as yet unnamed, and not hired until last night, has already saved hundreds of thousands of dollars on a 73-bed hospital, and the board hasn't re-

ceived any of that information yet. I find that more than what I can cope with.

**Mr. Turner:** The consultants have not been hired yet, according to the chairman of the board.

**Mr. Breagh:** Well, from that end of the table to this end of the table; they just got barely hired over here, and up here they have already saved hundreds of thousands of dollars on a 73-bed hospital. That's quite a stretch.

**Mr. Turner:** I think Dr. Dyer was talking in generalities about past experience.

**Mr. Breagh:** No, I am quoting from one end of the table to the other.

**Mr. R. F. Johnston:** As you heard, he put it in a very particular terms, I think.

**Mr. O'Neil:** Could we ask Dr. Dyer? Have you talked with any consultants that have been speaking with the board?

**Dr. Dyer:** They talked to several consultants.

**Mr. McClellan:** Which ones have you talked to?

**Dr. Dyer:** They had consultants who did an initial survey.

**Mr. McClellan:** Which ones have you talked to, sir? Have you talked to consultants who have not been given contracts?

**Dr. Dyer:** Yes, we talked to several consultants, but there was one consultant who did a survey.

**Mr. McClellan:** You've talked to consultants who have done workups on a tender and obtained from them the information that had been developed on the workup of the tender?

**Dr. Dyer:** No, they haven't had a contract with the consultant yet.

**Mr. McClellan:** I understand precisely what you have done, sir.

**Dr. Dyer:** No, the other consultant came in and did an initial survey, as many hospitals do.

**Mr. McClellan:** Yes, I understand precisely what you have done, sir.

**Mr. O'Neil:** Are these the people you have talked to, the ones who did the initial survey, the people who gave you the figure that there could be hundreds of thousands of dollars saved?

**Dr. Dyer:** That firm has done many surveys. These firms have done many surveys around the province, and I can quote you some of the figures they have identified. On the average, across the province in this kind and size of an operation, they generally find a saving of about \$2,000 a bed.

Mr. O'Neil: Were these people talking specifically about this particular hospital?

Dr. Dyer: No.

Mr. O'Neil: You don't have any particular figures of savings on this hospital?

Dr. Dyer: No, I haven't.

Mr. Breagh: That's not what you said. Less than five minutes ago, less than five feet from me, you said there were consultants working in this hospital who could identify a saving of hundreds of thousands of dollars. That's what you said.

Dr. Dyer: Mr. Chairman, I may correct the record.

Mr. Breagh: Well, I hope so.

Dr. Dyer: I said the consultants had to do the initial survey.

Mr. Breagh: Who are they? How about a name? Who was the consultant who did the initial survey?

Dr. Dyer: I can't reveal that.

Mr. Turner: The chairman indicated that before.

Mr. Breagh: I beg your pardon?

Mr. R. F. Johnston: Yes, but there is only one name that has been filed. Which is the one you are talking about?

Mr. Turner: I have no idea.

Mr. Chairman. Dr. Dyer.

Mr. Breagh: I want to point out to Dr. Dyer he is before a committee of the House. We are accepting him, not as a hostile witness or anything; and we are expected to believe what he says. He has said there have been consultants working in this hospital who have identified potential savings of hundreds of thousands of dollars. I want to know who they are, and I want tabled with this committee any indication, however flimsy, that they can save hundreds of thousands of dollars of administration costs in a 73-bed hospital. Put her down! Can you do that?

Dr. Dyer: The consultants are working in this field.

Mr. Breagh: Who are the consultants in this hospital? That is what I want to know.

Dr. Dyer: I can't reveal the consultants hired by that hospital.

Mr. Breagh: Oh, now, wait a minute, Mr. Chairman.

Dr. Dyer: They haven't even hired them yet, as I understand it.

Mr. Breagh: That's pushing it just a bit much. He can tell us how much they are going to save, but he can't tell us who they are.

Dr. Dyer: What I told you is these consultants' experience around the province.

Mrs. Berry: Mr. Chairman, might I ask Dr. Dyer how he knows whom we hired? As far as I know it hasn't been released by anyone from our board.

Dr. Dyer: The consultants you had to do the initial survey.

Mrs. Berry: We didn't have any company do a specific survey. We have had more than one company submit a proposal. I myself would be interested in knowing who you are trying to quote.

Dr. Dyer: These aren't the consultants we are talking about. Woods Gordon and Company are one of the consultants you have.

Mrs. Berry: Yes, that's right.

Dr. Dyer: I think they have made a proposal to you. As they said, in their experience when they examine operations that have not had consultants in before, for a 100-bed hospital they generally find figures in the range of \$2,000 per bed. That's their experience. We can quote experience from them in other areas; that's what they told us.

Mr. McClellan: Do you think it is proper for a management consultant firm that is being retained by a client, to disclose information to you?

Dr. Dyer: They haven't disclosed—

Mr. Turner: We don't know.

Dr. Dyer: We don't know. It's not information; they are just saying, from the—

Mr. Breagh: What do you mean, "they're just saying"? He's just saying them!

Mr. Turner: We don't know. He didn't say—

Mr. Breagh: What did he say, then?

Mr. Kennedy: He didn't say "the"—

Mr. Breagh: So it's not them?

Mr. Kennedy: Who knows?

Interjections.

Mr. Chairman: Order. Dr. Conlon would like to make a comment at this point. Dr. Conlon.

Dr. Conlon: Thank you, Mr. Chairman. I welcome the opportunity, as president of the medical staff, to be able to speak to the committee.

I think it's important at this stage of our proceedings that we don't lose sight of the actual situation as it now exists in Goderich. It's mainly this, if I could very briefly recap and go back over the last year when we were 101 beds. Of those 101 beds, 20 beds were psychiatric, 10 beds were chronic care, and 71 beds were active-treatment beds. As



of October 1978 we voluntarily reduced our active-treatment beds to 58 in accordance with the ministry restrictions of 43 beds imposed upon us. At the present time, we now have 43 active-treatment beds, we have 20 chronic-care beds for geriatric care, and 20 psychiatric beds.

The medical staff of the Alexandra Marine and General hospital feel the allocation of 43 beds for this year, 1979, and the proposed reallocation of 37 beds in 1980 constitutes a serious hazard to health care in our community. And why? Based on last year's figures, our percentage occupancy within the hospital has been well over 80 per cent, and above the figure of occupancy recommended by the Ontario Hospital Association, and other bodies throughout western hospital structures similar to ours.

Based on 43 active-treatment beds at the present time, we are running at 112 per cent occupancy by using other beds. Within the last year, we have evolved assiduously programs in our hospital of day care, surgical procedures and other procedures. We recognize there are certain budgetary restrictions that we have to live with, but the crucial point is this: When these statistics were available to the ministry they were based on referral source population and weighting factors which were not in accordance with current activity at the hospital, which will continue in the next two years. The reason for this is that we were reduced to three physicians—well, say four—because of resignations and deaths within our community in 1978, on which these figures were based. As of July of this year, we will have nine active-treatment physicians.

[6:00]

Therefore when these statistics were calculated they were based on a referral source to London, which had to be. Now this has changed. We do not envisage ourselves becoming a cottage hospital. We are a primary-treatment hospital, not a cottage hospital. We are also a secondary-treatment hospital. It's an ongoing process, with active surgical, medical, paediatric and psychiatric care. If our hospital goes to 37 active-treatment beds within the next year, the standard and quality of care is going to be seriously jeopardized. I am not going to go into detail, because we do not agree in the first instance with the statistical figures on which this has been calculated.

I am instructed by the medical staff to say that the statistics, the overall population, on which this was based—and I think I am right in saying this—was a little over 10,000 population, which is how we arrived at these

figures. We well know that Goderich is a lakeside town that's with a constantly fluctuating population. We know from, for instance, last year, there were 9,132 vacationers registered in Goderich and in the outskirts of Goderich. There were 39,000 people, that is taking into account three occupancies per car, registered at the local tourist booth in Goderich. I am not suggesting that the majority of these vacationers will become ill, but there inevitably will be repercussions on our hospital for a three- or four-month period of the year.

My concern as a physician is this: we must have at least 52 active-treatment beds. We recognize that the ministry is not a bottomless pit of finances and that there has to be some curtailment in certain areas. But based on any reasoned argument or discussion, and based on our population, even at 3.5—if we accept this 3.5 and accept the ministry decision in this area—we must have 53 active-treatment beds.

I hope I have made the reasons abundantly clear. We have family physicians in Goderich who are educated and trained and well qualified in a whole new era of family medicine. We propose to develop for our hospital in Goderich a standard of care similar to what is carried out in London; we want to do this in our town. We cannot, if next year we have only 37 beds to cater for a population of roughly 18,000 people. It's quite impossible.

We have known in the past, and this province has known, what dire straits faced us. I have been in Goderich for 14 years. I have gone through these dire straits when there were no physicians in the town, when we had to send patients elsewhere. We were faced with this nationally last year. We had only three physicians, so we advertised in every national newspaper, in every medical journal throughout Ontario and throughout Canada for additional physicians. Our lack of physicians became a major concern in the local press. With nine physicians now, 37 beds, based on a population of 16,000 to 18,000 people, is not adequate, I respectfully submit, Mr. Chairman.

Mr. Chairman: Thank you, Dr. Conlon.

Mr. Sweeney?

Mr. Sweeney: I wonder if your continual references to dire consequences was just a slip of the tongue?

Dr. Conlon: I use that word advisedly. If you would like to question me on that, I can give you a—

Mr. Sweeney: We have been very serious here. I thought maybe a little levity might lighten it.

Can I just go back again? I want to understand the active-treatment bed figures you used, because they are revealing, to say the least.

You started out with 71?

**Dr. Conlon:** Seventy-one, yes.

**Mr. Sweeney:** Somewhere back there. You voluntarily decreased it to 58 yourself? Is that what I heard you say?

**Dr. Conlon:** Yes, in the fall of 1978.

**Mr. Sweeney:** Okay, then you were told to decrease it to 43—or, excuse me, I guess maybe the expression is, you know, “We won’t pay you for any more than 43 so you might just as well do it.” Is that it?

**Dr. Conlon:** Well, no.

**Mr. Sweeney:** I understand you don’t get told to reduce, you are advised to do it in some other way.

**Dr. Conlon:** These were the guidelines that were submitted to us and which we tried, assiduously, to implement.

**Mr. Sweeney:** Okay, so, in fact, at the moment, at the “request” you now have 43.

**Dr. Conlon:** That’s right.

**Mr. Sweeney:** You are next being told to push it down to 37?

**Dr. Conlon:** That’s proposed for next year, 1980.

**Mr. Sweeney:** So between 1976-77 and 1980 you’re going to just about halve the number of active-treatment beds.

**Dr. Conlon:** Almost. That’s correct.

**Mr. Sweeney:** And what’s happening to the population of your area?

**Dr. Conlon:** Probably increasing.

**Mr. Sweeney:** So the number of people you are expecting to serve is increasing, and the number of active-treatment beds you’re expected to work with is just about being cut in half? That’s the reality?

**Dr. Conlon:** In fairness, I would say that the ministry has increased our allocation to probably 20 chronic-care beds. I have very grievous concerns in this area. Although I welcome this consideration, because we have a higher proportion of older people, there are inherent and very serious dangers in this.

If the chronic geriatric population increases to the point where almost 50 per cent of our active-treatment beds are geriatric beds, this is not the type of hospital we are. So we are saying we require more chronic-care beds than active-treatment beds for our geriatric population. There’s no statistic anywhere in the world that can vindicate this

in any way, but that is actually what’s going to happen.

**Mr. Sweeney:** Let me come at the point you’ve just made in another way. Mrs. Berry, I understood you to say that you have been authorized to increase your chronic beds from 10 to 20.

**Mrs. Berry:** Yes.

**Mr. Sweeney:** But the additional 10 are to be found in whatever money you can save from the management consultants’ report.

**Mrs. Berry:** That’s the way we interpret the minister’s letter.

**Mr. Sweeney:** What incentive is there for you to have a management consultant at all? You’re already getting the money; supposedly, you can spend it the way you feel you should. Why do you have to bring a management consultant in to save you money to do something you can do already? What’s the incentive? You’re not going to get any more out of it.

**Mr. Turner:** Sure you are.

**Mr. Sweeney:** No, you’re not. You’re going to end up with the same amount of money. They’re saying is, “If you save anything, you can use it.”

**Dr. Conlon:** I have an interesting observation there, Mr. Chairman, from the board meeting last night. We welcomed the independent consultants—

**Mr. Sweeney:** Excuse me. They’re not that independent.

**Dr. Conlon:** But there’s one point that was brought up by the board, and maybe it ought to be clarified. Is it a preconceived idea or a premise that these management consultants will say we are spending too much money? Is there any possibility that they might say, “This hospital is under-financed; they can’t possibly cope with the budget that has been allocated to them”? Indeed, some members of the board expressed serious concern at the meeting last night over our current financial situation. Even based on our 43 active-treatment beds, how possibly—and it became very emotional—were we going to meet these demands in the fiscal year ahead? But it was said that maybe this management consultant team will say it’s quite impossible for this hospital to manage on this allocation.

**Dr. Dyer:** Mr. Chairman, could I straighten some things out for the record? There is some confusion in numbers, Mr. Sweeney. The ministry did not reduce their allocation to 43 beds. I agree that 43 beds is the identified allocation at four beds per 1,000, but there’s a 10-bed cushion allowed on that. For the

record, the constraint this year went from 58 beds, and there were five beds constrained. It was reduced only \$60,000, in a sense—not by 15 beds, but by five beds. If you want to look at the balance, there were really 53 beds that remained funded.

**Mr. Breaugh:** From this end of the table I hear 43, and from that end 53.

**Dr. Dyer:** Mr. Breaugh, 43 is the number of beds at four beds per 1,000 but there's a 10-bed cushion—

**Mr. Breaugh:** What I want to know is, how many active-treatment beds are in the Goderich hospital? The people who run the hospital tell me 43; the guy at this end tells me 53. I'm more inclined to believe the people at that end, seeing it's their hospital and they can probably count up to 43 without management consultants.

**Dr. Dyer:** I'm only trying to indicate that as far as we know our records show they had 58 beds in operation as of October last year and five beds were constrained. If they shut down more beds than that, that's their option, but only five beds were constrained this year. From our funding point of view, that would be from 58 to 53 beds. I'm not saying they're not operating 43. Please don't misunderstand.

**Mr. Sweeney:** Let's follow it. If they choose to go back to the 53 you say they're supposed to be able to have, then they're going to be funded for it?

**Dr. Dyer:** They are funded. They were only constrained five beds. They were not constrained 15 beds.

**Mr. Turner:** How come the good doctor and the chairman both indicate they're only using 43?

**Mr. E. Taylor:** If I could comment on that, we initially tried to operate at the 53-bed level, but with the amount of funding being provided by the ministry and on the basis of budget projections, we just couldn't fund those additional 10 beds for any period of time during this fiscal year. We were faced with a situation of eliminating that 10-bed cushion right off the top and going to the 43 figure.

**Dr. Dyer:** For the record, the per diem costs in this hospital are running at \$161 a day versus their group mean of \$132 a day, so their costs are higher than their peers. This is one reason why we've asked management consultants to come in.

**Mr. Breaugh:** Who asked them again?

**Dr. Dyer:** Last year when the \$140,000 was returned to the hospital to offset a deficit they'd encountered, there was a commitment made by the hospital as one of the condi-

tions. One of the conditions was to engage management consultants. It was a commitment between the minister—

**Mr. Breaugh:** For these people over here, the board of the hospital, to engage consultants, but you didn't.

**Dr. Dyer:** No.

**Mr. Breaugh:** You just got the information off the consultants before they even hired them.

**Dr. Dyer:** No, we didn't get information.

**Mr. Chairman:** Mr. Taylor, do you want to complete your remarks? Then Dr. Conlon wants to make a statement.

**Mr. E. Taylor:** Yes. I would just like to point out that we are the only hospital in the grouping you're looking at that runs a psychiatric facility covering the entire county. We have 20 beds; that facility requires staff that you don't have in an active-treatment hospital, including psychologists, social workers and occupational therapists. We know that this accounts for a large part of that difference in our figures. We provide outpatient mental health facilities in Wingham. We would like to provide them in other areas of the county in accordance with our mandate, but because of limited funding we're not able to do it at the present time.

**Mr. Riddell:** Might I just add that the residual psychiatric-bed unit was transferred to the Alexandra Marine and General Hospital because of the closing down of the Goderich Psychiatric Hospital, which was one of the biggest mistakes that you people ever made, if you ever want to own up to it at some point in time.

**Dr. Conlon:** I wanted to add to that point. In fact, Mr. Chairman, you will find that our average duration of stay is a little bit above the national average. We're around 10 point something, which I think is extremely good, taking into consideration that we're a schedule one facility and we have 20 active-treatment psychiatric beds. Because of the nature of psychiatric illness, very often of necessity the duration of stay has to be longer. Mr. Taylor answered the point which was very relevant about our per diem costs, which was brought up.

**Mr. Sweeney:** I wanted to come at this psychiatric-bed section of the hospital as well. As the chairman well knows, though unfortunately I don't think Dr. Dyer was present, when we were going through the lengthy hearings with respect to the Lakeshore Psychiatric Hospital, one of the points I understood came out of that was that the ministry was trying to get into more community-based



psychiatric care and trying to get away from the large psychiatric hospitals wherever it was deemed advisable.

Is there no provision whatsoever to recognize that at least that 20-bed wing of that hospital is bound to be a much higher-cost operating facility, and that if in fact the inclusion of it in their total global pool of money is forcing them to down-run their active-treatment beds from 53 to 43 there's got to be some kind of rearrangement? This just doesn't seem to be fair unless I'm missing something very badly here.

[6:15]

**Dr. Dyer:** Perhaps I can help answer that for you. The hospital we saw before is a 100-bed hospital without a psychiatric unit. Their total global budget is \$3.1 million. In the case of the Goderich hospital, a 100-bed hospital, the total global budget is \$3.7 million.

**Mr. Sweeney:** That's a difference of how much?

**Dr. Dyer:** Of \$600,000 in their global budget. That's \$600,000 a year that this 100-bed hospital gets in addition compared to its counterpart in the same area.

**Mr. E. Taylor:** I don't think we should lose sight of the fact that Wingham is requesting additional funds to close that gap.

**Mrs. Berry:** Dr. Dyer, it's five miles down the road. We realize the duplication of services and expenses. I'm sure that this is where the management consultant firm will come up with savings. We know that they're there too. We have to pay rent there. We pay for laundry and meals. We have an extra person for medical records, and extra housekeeping. If these were moved into our own hospital, we'd have these savings.

The reason why we didn't jump in and get management consultants before was that we had just hired a new administrator. We felt that he should be given the opportunity to see what savings he could generate, and he has. We've cut our housekeeping staff in half. We've closed down our laundry unit and we are now sending our laundry to London. There are many areas where we've already cut back on expenses. It's going to be interesting to us to see what expenses the management consultants can find in our general hospital as such without the psychiatric unit.

**Dr. Conlon:** I'd like to acknowledge that the ministry has been generous to us in developing a mental health-care program for Huron county. I direct this, so I know they have been generous in this area. A lot of funds are involved. A day-care centre in Wingham has been paid for and the psy-

chiatric staff comes off our budget. There's considerable extra expense involved in this. These things just don't happen without some additional funds. When the required additional funds are taken off the overall budget, you will find that the increased allocation hasn't been all that great for our active medical, surgical and other services.

**Mr. Sweeney:** Just one last question, Mrs. Berry, you were here when the Wingham hospital people spoke to us. They said they don't offer certain kinds of medical services. There's a severe limitation in what they do with respect to surgery of any kind and there's a severe limitation as to what they do with respect to home-care services. Your hospital, on the other hand, offers a total range of services. Consequently, I'm a little at a loss to see how the two of them can be compared. It's like comparing a secondary school with an elementary school. We know that they're just not comparable. Is that a fair statement?

**Mrs. Berry:** I agree. I'm afraid we get a little bit tired of being compared with these other hospitals when they aren't comparable.

**Mr. Sweeney:** Dr. Dyer, I'm listening to the witnesses from two different hospitals and I get the impression we're dealing with two very different kinds of hospitals.

**Dr. Dyer:** I was only trying to answer your question about funding. You asked whether there was an additional amount of funding provided for the psychiatric care. There is. There's \$600,000 in this hospital's budget in addition to that of a comparable hospital not offering psychiatric care.

**Mr. Sweeney:** Excuse me, doctor—just so we're on the same wavelength—the comparison you made was between Wingham and Goderich. Those are the two figures you gave us. What I'm trying to suggest is that much of that \$600,000 probably is also included in the fact that Goderich is a very different kind of hospital, offering a much wider range of services above and beyond the psychiatric care. So it doesn't strike me as being apt to say that \$600,000 can be applied to psychiatric care. Some of it maybe, but certainly not all of it.

**Dr. Dyer:** I acknowledge that—it's not all. I didn't mean to say it was all applied to psychiatric care. But whatever different services they operate, the basic medical, surgical, obstetrical and pediatric services are comparable, in terms of that range of services, between the two hospitals.

**Mr. Sweeney:** I think I've made my point, thank you.

**Dr. Dyer:** There was one point—again for the record—the question raised by the doctor

about \$200,000—but not from the budget base.

We have made a number of other changes in the operation. I think an important consideration here is that in the study done by Woods, Gordon, in one of the smaller of the four hospitals that was mentioned by Mr. Hayes from Wingham, they were able to identify only something in the area of \$10,000 to \$12,000 in savings. Anything like that wouldn't even pay our consultants' fees, let alone operate our chronic beds.

**Mr. Breaugh:** What's the name of that company again?

**Mr. E. Taylor:** Woods, Gordon.

**Mr. Breaugh:** Oh, that's the one that is saving hundreds of thousands of dollars. They only saved \$12,000, did you say?

**Mr. E. Taylor:** Yes, it was around that.

**Mr. Breaugh:** Did they fall a little short in their savings?

**Mr. R. F. Johnston:** That was before they were working for the minister.

**Mr. Breaugh:** Yes, they're in a different league now.

**Mr. E. Taylor:** As Mrs. Berry has pointed out, we have reduced staff in a number of other areas, including housekeeping. We've gone to central laundry, as the ministry suggested, to save substantial sums of money, which we still don't feel were there. We've had consultants from the Ministry of Health come in and look at our nursing staffing, and they say we're just above the danger level right now; to reduce the staffing any further is not in the best interests of the patients.

We honestly don't see where we can save any large amounts in the system there now, as we're operating it, without reducing service and perhaps eliminating some services that we now profess to have. I'm a firm believer that, if you profess to have an emergency department in your hospital, you'd better have it 24 hours a day; you shouldn't run it eight hours and then shut it down. If we're going to operate at the existing level, we cannot do it with the funds we have, and we don't feel the management consultants will come up with enough to make up the difference.

**Mr. Turner:** Just out of curiosity, Mr. Taylor: In a small community, how do you operate your emergency department 24 hours a day?

**Mr. E. Taylor:** We have an on-call roster of medical staff, and they are available 24 hours a day.

**Mr. Turner:** You don't have anybody on the hospital, though?

**Mr. E. Taylor:** Usually, during the daytime, there will be one of the medical staff there, but there is an on-call list for evenings and nights.

**Mr. Turner:** There isn't a doctor there 24 hours a day?

**Mr. E. Taylor:** No, there isn't.

**Mr. O'Neil:** Do you have a nurse on duty, though, in the emergency department?

**Mr. E. Taylor:** Yes, we do.

**Mr. O'Neil:** One nurse?

**Mr. E. Taylor:** In the summertime, the busy part of the year, we make sure we have staff there 24 hours a day. But in the wintertime, when the volume of outpatients and emergency patients declines, we don't staff it at nights.

**Mr. O'Neil:** Some of your other comments were interesting. The health costs in the province have been quite high and I can see where there have to be certain savings. As I mentioned to you, I think a lot of the boards and hospitals have done just as your board has done. You've identified some of these frills and you've cut them out. My theory is the government, in some cases like yours and some of these others we are likely to hear, has just gone too far.

I think they should have gone to the point where you said you had these things and you had cut them down, but there's a certain level at which we have to maintain small hospitals. You mentioned the need to keep the doctors in the hospital, to keep staff, to give proper care and to be able to keep enough nurses on staff to make sure these people are looked after. The government certainly, and the ministry staff, has to certainly have another look at it. It is our fear they have just gone too far in some of these things.

**Mr. Chairman:** Dr. Conlon, would you like to make a comment?

**Dr. Conlon:** I would like to mention to this committee very briefly that there is an area in which there is considerable overexpenditure. I would like to inform the committee of the geographical situation of the psychiatric unit, which is four and a half or five miles away from the general hospital setting and great additional expense is inevitably incurred. It is very dear to all our hearts, including the board's, that one day we will have the psychiatric department integrated as it should be and relocated within the hospital setting. There may be an additional immediate expenditure incurred in the line



of structural alterations, which may not be all that great really, but certainly there will be tremendous saving over a period, I would say, of 10 years. I would respectfully submit that in less than 10 years this relocation would pay for itself. I feel sure the management consultants will find in their overall evaluation the wasted money—I won't say wasted; it's not wasted because we're trying to do a good job where we are—how this additional expense could be obviated by having the unit structurally with the mother hospital rather than five miles away.

**Mr. O'Neil:** Maybe I could close, Mr. Chairman, because I know there are others here. I would like to ask Dr. Dyer, in his discussions with the minister, after having heard what has been presented here today and what will be presented, particularly in these two cases we have heard today, do you not feel there is within smaller community hospitals a certain point beyond which you cannot tell these people they have to stretch themselves? In other words, when they're down to the point where they have made certain savings, there has to be a point where you can't say cut more beds, cut your budget more, reduce your staff. I think it has just gone too far.

**Dr. Dyer:** Mr. Chairman, I think that's the reason the minister deliberately spoke about the small hospitals. I haven't got his text here but I know he did say we recognize the needs of small hospitals. We know there's a size smaller than which they are not viable. We are examining that question very carefully. We have structured a session with the small hospitals in September to look at this matter. As a matter of fact, we had consultants in ourselves today who are publishing a paper on the subject.

**Mr. Breaugh:** Who were they?

**Dr. Dyer:** They are different consultants, Mr. Breaugh.

**Mr. Breaugh:** Same suit, different colour.

**Dr. Dyer:** These consultants are examining small hospitals across the country. We can assure them and the minister has reassured them.

**Mr. O'Neil:** You know one thing that upsets me, especially in the health field, is that these people are continually getting stalled. "We're going to bring in consultants." "We're going to do a study." "We're going to have a meeting." In the meantime, you're cutting them back.

To me, it's like a lot of the government programs today. It almost looks as if it's planned stalling. You tell them you're going to do a study or something like that, you put

them off, and meanwhile, we cut them back on their beds, and we cut them back on their expenses.

**Mr. Turner:** Nobody is putting anybody off here.

**Mr. O'Neil:** They need more money.

**Mr. Turner:** They were asked two years ago, I understand, or at least a year ago, to engage consultants in order to identify—

**Mr. O'Neil:** You just heard them say how much they've cut.

**Mr. Turner:** I know.

**Mr. O'Neil:** They need some help now. They don't have to wait for a meeting in September or next year or something like that. They need some assurance that they're going to be able to keep their beds or that they're going to be able to get some funds.

**Mr. McClellan:** I want to go back to the question of management consultants. A year ago the ministry asked the hospital, Mrs. Berry, to obtain management consultants.

**Mrs. Berry:** Yes.

**Mr. McClellan:** Was it a request or was it an instruction?

**Mrs. Berry:** It was part of the conditions whereby they gave us the \$140,000.

**Mr. McClellan:** It was an instruction to you.

**Mrs. Berry:** Yes.

**Mr. McClellan:** At that time, did they give you a list of management consultant firms to approach?

**Mrs. Berry:** They said that they would supply us with a list.

**Mr. McClellan:** And then proceeded to do that?

**Mrs. Berry:** Yes.

**Mr. McClellan:** How many of those firms did you approach for proposal tenders?

**Mrs. Berry:** Five.

**Mr. McClellan:** Did you receive proposals from all five?

**Mrs. Berry:** Yes, we did.

**Mr. McClellan:** In those proposals put forward to you, were there any figures as to estimated cost savings that would result from their work?

**Mrs. Berry:** No, nothing definite. They all assumed they could find savings.

**Mr. McClellan:** If I understand what you are saying, they never provided you with any figures as to how much money, even in a ballpark sense, that could be saved?

**Mr. E. Taylor:** No, not in any of the proposals. There's no reference to savings. They



was with reference to the referral patterns in the future. I wanted to make it clear the referral patterns are calculated each year. If there's a change in your referral pattern as a result of additional physicians in your area, then of course that will change your bed allocation.

The 37 beds are only identified this year as the number of beds that would be at 3.5; that doesn't mean to say, by any means, that your hospitals are expected to go to 37 beds. That's a misconception a lot of people have, and it's unfortunate. It was shown as 37 beds if 3.5 was applied.

That was sent out very early in the year or perhaps it was the end of last year to indicate the guidelines that were being considered. As you know, the guideline this year is four beds per thousand, not 3.5. Next year there will be a recalculation of the bed allocation based on whatever changes will happen in terms of your patient referral. So it could change your allocation considerably.

**Mr. Riddell:** Mr. Taylor has a response.

**Mr. E. Taylor:** I was just going to ask Dr. Dyer, Mr. Chairman, how one is to increase their referral base when you already are working at the guideline. If our allocation is 43 beds for this year, projected for 40 next year and 37 the following year, without having additional beds and an increase in the number of medical staff in Goderich, how are we going to justify more beds?

**Dr. Dyer:** Mr. Chairman, I go back to the number given previously—that is, you are operating 58 beds of which we constrained five. So as far as we're concerned, you are still authorized to operate 53 beds—which is above four beds per thousand.

**Mr. E. Taylor:** We would like to operate 53 if we had the funds to do it.

**Dr. Conlon:** Mr. Chairman, I know Dr. Dyer would like to be acquainted with what happened in Goderich at this time. With the medical staff and the hospital board it was only with the greatest of discretion and understanding that the 43-bed allocation was accepted. There was a long fought-out battle, which was extremely emotional, in which I was intimately involved as president of the medical staff. We tried very hard to get the staff of the hospital to accept the 43-bed allocation.

Mrs. Berry, our chairman, knows what we have been through. We were led to understand explicitly and absolutely there was no question at the present time of us having 53 active beds. It was an absolute impossibility.

I would be delighted to go back to the medical staff and say that, as of now, we can have 53 active treatment beds. I think this would be the best news we've had in Goderich during the last very difficult year.

**Mr. Turner:** I think the two doctors have anticipated my question, although there seems to be still some confusion in the minds of a lot of people about the numbers involved.

**Mr. Sweeney:** That is the understatement of the afternoon.

**Mr. Turner:** I'm interested in hearing the board and the administrators and the doctors say they're thinking in terms of 43 and the ministry, apparently, according to Dr. Dyer, is funding them at 53.

**Mr. Riddell:** He is not funding them at 53.

**Mr. Turner:** He said, unequivocally, that he was.

**Mr. Riddell:** The board said—

**Mr. Turner:** I know, but this argument isn't going to be resolved here and now.

Let me ask you, Mrs. Berry, are you anticipating further meetings with the ministry?

**Mrs. Berry:** We had hoped to arrange a meeting to clarify the letter anyway.

I would like to point out at this time that while Dr. Dyer doesn't think the \$60,000 is very much money, it is to us and with that \$60,000 cut in our budget we actually only received an increase of 2.86 per cent, nowhere near the four per cent that was the provincial average. Naturally, we had to cut back on beds; with inflation going up nine per cent and us getting 2.86 per cent, something had to give.

**Mr. Turner:** In actual fact, what you're saying is that even though on paper you may be funded at 53, for all practical purposes you have to operate at 43. Is that a fair interpretation?

**Mrs. Berry:** Yes, I suppose so. We still question whether we're getting sufficient funding for 53.

**Mr. Turner:** Is this something that you have talked to the management consultants about, or your proposed management consultants?

**Mrs. Berry:** The management consultants are going to look at all aspects of the operation.

**Mr. Turner:** Hopefully, then, they may be able to identify it on a much closer basis.

**Mr. Riddell:** It seems to me you have just arrived at a recent settlement with the union too. You might indicate what that is and how

in the world you're going to be able to pay for that with a 2.3 or 2.5 per cent increase. How much was it?

**Mrs. Berry:** Yes, it was 5.7 per cent for the first year under the Service Employees International Union contract.

**Mr. Sweeney:** It's closing over 10 beds.

**Mr. Turner:** That's fine, Mr. Chairman. Thank you very kindly.

**Mr. Riddell:** You're expecting miracles from these people.

**Mr. Ramsay:** Mr. Chairman, most of the questions I had to ask have already been asked, with probably one exception. Do you have a district health council in your area, Mrs. Berry?

**Mrs. Berry:** No, we don't.

**Mr. Ramsay:** You made a comment earlier that I sympathized with and that was that in a sense you felt the autonomy of the local boards was diminishing over the years as the Ministry of Health encroached on your responsibilities. I felt that same way when I was chairman of a hospital board and I said as much during an annual meeting and in a statement I made at the time. However, to follow through for just a moment, the health councils came along after that. I had very serious doubts and reservations about the role of the health council. I suppose I'm not asking a question but I'm making an observation here.

Since that time, I have found that the health councils have restored, in my estimation at least, some of that distance that was created between the local boards and the ministry. We had a level involving local people. We had a level of authority with people who were inclined to look at the health-care problems in our area, and it restored, to a certain extent, the widening gap between the ministry and the local board.

I just make that observation because I felt exactly the same way as you do now, that the ministry was encroaching too much on our operations and that we were completely losing our autonomy. I think we're getting a little bit of it back now through the health councils.

**Mr. O'Neil:** Mr. Chairman, I would like to say that, again, I realize the minister may have had other commitments, but I'm very sorry that he can't be here today to listen to the presentations we have been hearing, because I think, sometimes, the minister and his officials are dealing with bigger centres, bigger hospitals and they sort of lose touch with some of our smaller communities and, in this case, some of our smaller hospitals.

Dr. Dyer has been here today and he has had to try and answer some questions that I think should have properly been put to the minister. If the minister had been here, I think he would have gone away appreciating a little more the problems that occur in some of the smaller hospitals around the province.

[6:30]

Health councils were mentioned and your not having one. I have a real fear of health councils too. As I mentioned yesterday, I think they are asked to take the brunt of a lot of the decisions that the minister should be taking; he leaves them to the health councils.

I'm also afraid that a lot of the smaller hospitals find it very hard to hold their own when they're thrown in with a bunch of larger hospitals and larger communities. That's one of the initial fears of some of the smaller communities similar to mine. There may be a lot of good features to health councils but, on the other hand, there are a lot of fears on the part of some of the smaller communities and hospitals.

I'm going to put a little plug in for your local member by saying that, in getting up in the Legislature and trying to bring this to the attention of the government, he certainly brought it to the attention of our caucus. A lot of our members there share your concerns, and they try to have us understand not only your concerns, but also those of a lot of the other smaller communities and hospitals across the province.

I want to ask, do you feel there is much fat in your hospital? In my own hospital in Trenton, I figure they have cut back over the last number of years on a lot of things that might have been frills to bring it down. Then, as I mentioned yesterday, when their budgets are increased, it's based on their present budget, and there's hardly any fat left to trim. I just wanted to ask you that.

**Mr. E. Taylor:** Last summer, when we encountered financial difficulties, we were required to lay off about 15 people at that point to bring our budget back in line. This was very disruptive to the hospital, as you can imagine; the staff really haven't recovered. They're not really looking forward to having management consultants come in at this early date; that's one of the reasons why we have been somewhat hesitant in doing this.

We are really interested in the morale of the operation. We have to maintain a reasonably good service with the people we employ at present. As a result of those changes, we did trim our operating costs last year by

just outlined a few areas that they would be interested in looking at.

**Mr. McClellan:** As I understand it, the board awarded the contract last night?

**Mrs. Berry:** Yes.

**Mr. McClellan:** What was the name of the firm that was awarded the contract?

**Mrs. Berry:** It happens to be Woods, Gordon. I'm curious to know how the ministry knew that.

**Mr. McClellan:** That's my next question, and that's to Dr. Dyer. I want to ask Dr. Dyer very simply and very directly did you talk to Woods, Gordon today?

**Dr. Dyer:** I did not personally talk to them but our staff, the team from that area, have discussed it with them.

**Mr. McClellan:** Today?

**Dr. Dyer:** Not today.

**Mr. McClellan:** When did they discuss this with you?

**Dr. Dyer:** I think it was last week.

**Mr. McClellan:** When did your staff have discussions with Woods, Gordon?

**Dr. Dyer:** That would be last week.

**Mr. McClellan:** Did your staff relay information to you with respect to an estimate of cost savings that had been suggested to them from Woods, Gordon?

**Dr. Dyer:** They reflected that Woods, Gordon indicated that when they do these kinds of studies they expect to find savings and they gave us an estimate of that.

**Mr. McClellan:** They gave you an estimate?

**Dr. Dyer:** No, from their experience they expect to find something in the order of about \$2,000 per bed in terms of the size of the hospital. That's how they estimate the kind of savings.

**Mr. McClellan:** Did your staff talk to any of the other firms that were approached by the hospital for a proposal?

**Dr. Dyer:** I don't know that. They didn't report that to me.

**Mr. McClellan:** They only reported to you on the one that was going to get the contract?

**Dr. Dyer:** I imagine they did, but I'm not sure. I could clarify that but I'm not sure.

**Mr. McClellan:** I think you had better clarify that, Dr. Dyer, when you go back to the hospital.

I want to ask you what your feelings are about this, Mrs. Berry.

**Mrs. Berry:** My own personal feelings are that perhaps we should take a second look at whom we are going to hire.

**Mr. McClellan:** It was your expectation that you were the management consultant firm's clients?

**Mrs. Berry:** Yes. This was a great concern expressed at the board meeting last night that the contract would be between the hospital and the consulting firm and that the details would be kept confidential until there was a final draft.

**Mr. McClellan:** Who is paying for these consultants' reports?

**Mrs. Berry:** The ministry hopes to pay for them out of the savings.

**Mr. McClellan:** It comes out of your budget, does it?

**Mrs. Berry:** I suspect we have to pay for it and then we'll be reimbursed out of any savings.

**Mr. McClellan:** The statement in the May 16 letter is "I would like to reaffirm the ministry's position that any consultants' fees for cost and containment studies may be paid out of the savings generated."

[6:45]

**Mrs. Berry:** Yes.

**Mr. McClellan:** I understand that to mean that it comes out of your budget. Is that your understanding?

**Mr. E. Taylor:** The contract is with us; we would have to provide the funding to them.

**Mr. McClellan:** You are the client of the management consulting firm?

**Mrs. Berry:** Yes.

**Mr. McClellan:** I assume then that you feel there has been a violation of what you understood to be a confidential relationship between you, as client, and the management consulting firm, as professional management?

**Mrs. Berry:** Yes, I would consider it so.

**Dr. Dyer:** Mr. Chairman, can I clarify that? I can answer your question. It was Mr. Taylor who spoke to one of our staff—

**Mr. McClellan:** Mr. Taylor is?

**Dr. Dyer:** The administrator. He spoke to one of our staff and said they were considering Woods, Gordon because Woods, Gordon had experience with small hospitals.

**Mr. McClellan:** So then your staff proceeded to discuss with Woods, Gordon what work they were doing for the hospital?

**Dr. Dyer:** Yes.

**Mr. McClellan:** Sir, I regard that as unethical.



Mr. Breaugh: That is the polite word.

Mr. McClellan: Is that normal practice in the Ministry of Health?

Dr. Dyer: Is what normal practice, sir?

Mr. McClellan: For you to have discussions with management consultants who have been retained by client hospitals; is that normal practice in the ministry?

Dr. Dyer: I think our staff discuss from time to time with the ministry consultants what they are doing around the province—

Mr. McClellan: I wonder if the hospitals know that.

Dr. Dyer: —and we have frequent discussions with them, as a matter of fact. I had a management consultant from another firm in today, with reference to hospitals in the north.

Mr. McClellan: Do you suppose the hospitals know that you are doing that?

Dr. Dyer: Yes, it is a study they are filing with us.

Mr. McClellan: I am sorry.

Dr. Dyer: The consultant firm brought the study in for the hospital.

Mr. Breaugh: Why didn't this hospital know.

Dr. Dyer: It was the administrator who told one of our staff they were considering engaging Woods, Gordon.

Mr. Breaugh: There is a little difference between considering engaging and the way you put it.

Mr. Turner: Yes, but on the other hand, let's put things in chronological order. Mrs. Berry said quite clearly the board did not make a decision until last night, so, obviously, Dr. Dyer is referring to a conversation, I think last week was what he said.

Mr. Breaugh: So he knew before they made the decision?

Mr. Turner: He couldn't have.

Mr. Breaugh: He said he did.

Mr. Turner: How could he, if the board hadn't made a decision?

Mr. Breaugh: I concur with your findings, but that is what he said.

Mr. McClellan: As far as I am concerned, Mr. Chairman, the question was asked and answered by the representatives from the hospital.

Mr. Sweeney: I have one short question, Mr. Chairman, and I think maybe Mr. Taylor can help answer it, or Mrs. Berry.

Other than the reason given, why else did you choose Woods, Gordon, or was that the only reason?

Mr. E. Taylor: Basically, the number one reason we selected them was their experience in the field and that they have done a number of cost containment studies. Some of the other firms that were referred to us as possible candidates for the project had done a lesser amount of work, in some cases, perhaps, only one cost containment study. We also liked their approach to it, their association with the board and keeping in touch with the board as to the progress on what they may find. This was important to the board.

Mrs. Berry: I might add that one of their proposals was that they implement changes as they go, rather than bring in suggestions at the end and have the board or the staff implement them. They do the implementation themselves.

Mr. Sweeney: They would participate in the management of the implementation of the changes?

Mrs. Berry: Yes.

Mr. Sweeney: If that was your wish.

Mrs. Berry: Yes. They work with a committee of the board.

Mr. Sweeney: Thank you. That is all, Mr. Chairman.

Mr. Chairman: Thank you very much. We are sorry to keep you so late. The only good thing about this is you will miss the traffic when you are going back home. Thank you very kindly for coming and making your presentation.

Mr. R. F. Johnston: On a point of order.

Mr. Chairman: Mr. Johnston, on a point of order.

Mr. R. F. Johnston: I understood from yesterday's comments that we would be getting tabled with us today the health council's bed-need studies, on a question by Mr. Cooke, as I recall. Is that here today?

Dr. Dyer: No, it isn't. They are being prepared and assembled.

Mr. Chairman: We will reconvene tomorrow at two o'clock.

The committee adjourned at 6:50 p.m.





No. S-20

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Wednesday, May 30, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

WEDNESDAY, MAY 30, 1979

The committee met at 2:06 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Chairman:** We will commence the meeting this afternoon. The first group before the committee is the Ontario Hospital Association, and it's represented by its president, Professor J. W. Wevers, and the executive director, Mr. Alan Hay. Gentlemen, we are pleased to have you here. We understand that you do have some time constraints, so we won't waste any more of your time, we'll proceed.

**Mr. Hay:** do you have any opening comments you wish to make?

**Mr. Hay:** No, Mr. Chairman, we were not advised of any particular terms of reference; also, we were very short of time, from the time we were invited to appear.

**Mr. Chairman:** We understand that, for which we apologize. We were under some difficulties in that respect ourselves, so it's perfectly understandable.

**Mr. Conway:** Mr. Chairman, you might just, on a point of order, indicate what the time constraints are under which Mr. Hay and Professor Wevers are—

**Mr. Chairman:** I believe two days ago it was indicated—

**Mr. Conway:** No, I don't mean it in that way.

**Mr. Chairman:** Oh, I am sorry.

**Mr. Conway:** I understand they will have to leave at a certain time.

**Mr. Chairman:** Oh, I am sorry, three o'clock, is it, when do you have to leave?

**Mr. Hay:** Yes, by about then.

**Mr. Wevers:** It could be; not too much later than that.

**Mr. Conway:** Sir, I appreciate that.

Gentlemen, I want to indicate again my unhappiness and that of my colleagues about the short notice. As you may be aware, this committee has had really a two-part mandate, one of which has been dealt with in the matter of the Lakeshore Psychiatric Hospital. The second term of reference dealt in general

terms with the active-treatment bed ratios and the impact that those new ratios were having upon the public hospital sector in Ontario. We are using, as our beginning point—or at least I am—the announcement by the minister to hospital officials as of January 19, 1979, in which the new policy was made known.

I want to ask both Professor Wevers and Mr. Hay to comment in general on what they think about the new ratio, 3.5 and four, for southern and northern Ontario regions respectively; how it was arrived at, and to what degree they were consulted, as an association. I ask, also, how they feel in general about the implementation of this ratio over the course of the past number of months.

**Mr. Wevers:** I have no idea how the figures of 3.5 and four were calculated. As far as we are concerned, this is what the government has done; and, no we were not consulted about that.

**Mr. Conway:** Professor Wevers, just for the record, your professional and academic background is in—

**Mr. Wevers:** Near-Eastern studies. I am an authority on ancient Near-Eastern languages. That makes me really top dog in the hospital field.

**Mr. Conway:** That was really why I asked the question; I wasn't aware that your background was in that field. I was going to ask whether or not it was in the area of hospital administration, perhaps.

**Mr. Hay:** As you may or may not know, Mr. Chairman, Professor Wevers is chairman of the hospital board and has been a board member for many years.

**Mr. Conway:** What I wanted to ask both of you gentlemen is to comment on whether or not you see any kind of active-treatment bed ratio as being optimal. Is it something that is so localized, so regionalized, as to belie any province-wide application? What are your thoughts on whether or not a five-, three-, or four-bed ratio is, in fact, practicable on a province-wide basis?

**Mr. Wevers:** Using numbers like this is simply an illustration of the old notion that figures don't lie. It depends on what figures

you take. What do you mean by an active-treatment bed? If you have got a lot of specializations on the side, you can reduce your active-treatment bed ratio to one per thousand. As long as you have got plenty of other beds, it doesn't really matter.

So it depends on your definition. It depends on the kind of patient you put into the bed. I am not quite sure what an active-treatment bed is by definition. I am not trying to evade the question, but I would like to know what you mean by the number.

**Mr. Conway:** Do you get the impression, as some in the hospital and health community do, that such ratios are, generally speaking, more reflective upon the budgetary position and the budgetary exigencies of the day and less related to good health-care planning requirements?

**Mr. Wevers:** This is the government's position. I don't care who is in government, it is the government's responsibility to determine how much money is available for this program, for that program, and so on. I'll abide by that, somehow or other. I think it's probably just a bit specious to interpret it and then say, therefore, it should be that kind of ratio per thousand. I don't think that is really based on an analysis of the needs of the populace, but rather on the availability of resources to support that. That may be a valid way of doing it, but I think that's the way it is done.

**Mr. Hay:** If I could add a little to that. In earlier days we saw the number of active-treatment beds increased. Since those days, they have been coming down. There are countries, though, that have fewer than 3.5 active-treatment beds per thousand of population. When the numbers were going up, we in the association endeavoured to discover if there really was, in answer to your first question, a clear statement anywhere or any research that proved how many beds were necessary.

But in support of what Professor Wevers has said, we don't become sick according to some numbers that someone decides on. There are countries that get by with fewer active beds than are contemplated in Ontario. We are not living with 3.5 yet; it is being talked about, but that's not the figure yet.

Where there are other beds—convalescent, rehabilitative, chronic, and whatever—in more generous numbers, you can get along with fewer active-treatment beds, without any hardship.

**Mr. Conway:** On that point, Mr. Hay, it is clearly the desire of this ministry relatively speaking, to wind down a previously high level of active-treatment beds. In the words

of the minister, to convert certain of those beds to alternative uses; in particular, chronic and allied chronic-care facilities.

Given the fact that at present, many hospitals in Ontario are facing the clear budgetary import of that policy, are you pleased, and do you feel confident that we are nearly ready in those other areas, which are clearly a prerequisite, before you can retire or otherwise convert active-treatment facilities? Do you feel we are in a position in Ontario to say that we have a sufficient minimum of chronic-care facilities so that we can scale down the level of active-treatment beds?

**Mr. Hay:** The answer to that is that it is a very difficult question to answer. I suggest that whether we reach the right or wrong number, is conditional on whether there are demands for more beds or whether we have empty beds. I am sure that across this province there are some places where occupancy of active beds is lower than some other places. I know that to be true.

[2:15]

We also know, as I am sure this committee does, from reports of the council of health and others, that in Metro Toronto investigations have been carried out which showed about 10 per cent of the active beds at a given point were occupied by chronic patients. You can argue that that was a misuse of the beds, granted. You can argue, though, that we didn't need 10 per cent of the active beds as active beds; we actually needed 10 per cent more as chronic beds. Now that is a simple deduction, if you will, from the figures. We know that in some communities, where beds are more occupied to a higher percentage of the year than some others, it is difficult for them to shut active beds without extra chronic facilities being made available.

**Mr. Conway:** Is there a pattern apparent to you, Mr. Hay, and your administrative staff, from your membership across the province? Is there a pattern of concern, a pattern of unhappiness, about the way in which these new active-treatment-bed formulae are impacting upon their operation?

I presume you are hearing what all the members, or many members, are hearing from their individual hospital boards, unions and allied professional groups, that in some cases, there are very serious difficulties; that all sorts of problems are arising. What I am asking you, because you are a province-wide organization, is is there a pattern of concern, a pattern of objection, which is being raised at present to the minister's policy announcement of January 1979?



**Mr. Hay:** Over the last two or three years of increasing constraints, the concern of hospital trustees and administrators has been great. There is no question that the second year of the present constraint at the same level is very difficult. Our advice to hospitals has been that they should take up with the ministry, right away, their grounds for believing that they'll be in real trouble. We are less than two months into the new fiscal year at the moment, but we know already of hospitals that have done that, and we know the ministry is talking to them. We urge any hospital that has trouble to go and see the minister and the ministry. We know that this is producing results.

**Mr. Conway:** That is the question that I would proceed with then. From the basis of that advice, have you had sufficient evidence from your membership that where that advice has been acted on, the individual hospitals have been reasonably satisfied with that avenue?

**Mr. Hay:** It is early yet, but we are definitely hearing of the ministry saying to hospitals, "If you can make a case which we can recognize, we will help you." Now, bear in mind though, it is early in the year.

**Mr. Conway:** Does it concern you that that kind of procedure clearly militates in favour of certain situations? It seems to me that a hospital board that is reasonably close to the Hepburn Block—I'll comment not at all on the arrival of the honourable Minister of the Environment—does it not concern you, that for your membership, it seems it would be much more likely that if you lived within reasonable distance of the Hepburn Block and could make more visits, and could get a board that was very vigorous, very negotiations-oriented, that then you are going to exact from this process your fair reward? If you are not so disposed, is it likely that you will come up short on what should be a matter of right and a matter of everyone getting their entitlement without having to go and plead their case several times in the presence of the minister and his oak-panelled chamber?

**Mr. Hay:** We have seen no pattern which showed that the only ones to get redress are those nearest to the minister's office. I would have to say that we recognize that hospitals all over the province have their ways of putting their cases very strongly. When you get a level percentage increase, or virtually a level percentage increase, applied, it doesn't always hit evenly. Some people are immediately more concerned than others. This can be historic—a labour settlement many years ago, rather higher than the rest of the pat-

tern, made that cost higher. They may suffer as time goes on. We know enough of the statistics of hospitals, through a quarterly service that we help them with, to know the variations between hospitals.

**Mr. Conway:** Just a final point, Mr. Chairman, recognizing that the time allocation is a problem today. I don't detect from you, Mr. Hay, any unusual or immediate concern about the nature of a policy which concerns a number of the members and a number of the citizens of Ontario. I gather from your statement—and I just want you to have a chance to respond to this—that you are leaving an impression that, yes, there are perhaps some problems, but they can be negotiated to fair settlements by means of the boards and the ministry's staff meeting as often as required—that really we are not experiencing any undue difficulty as the result of this new bed ratio. Is that a fair representation? Because that is the clear impression I get from your presentation here today.

**Mr. Wevers:** If I may say a word to this. I think that impression is quite wrong. If by that you mean that we in the hospital field are sufficiently naive to think that we can make do with say a 4.5 per cent increase when the inflation rate is close to 10, that of course simply isn't true. I think what we are trying to reflect is a responsible caution that we are aware of that. No, we think we need more money. I think you won't find any hospital that would disagree with that. On the other hand, we also try to act as responsible citizens. If this is the kind of restraint that must be put on us, well, we don't have to like it but we'll have to live with it. I'd rather put it in those terms than in the terms in which you are trying to put it.

**Mr. Conway:** When did you first hear about the small hospitals conference for some time in September that the minister announced in the committee on Monday?

**Mr. Hay:** Some time ahead of that.

**Mr. Conway:** Could you indicate whether it was a week ahead, a month ahead, a year ahead?

**Mr. Hay:** No, no, no. We have had small hospital conferences, as an association, for years. This is one in which the minister himself and others have taken a more personal interest, a more direct interest.

But if I could follow along on the answer to Professor Wevers, we realize the predicament of the government with a heavy deficit; all hospital people know that. As Professor Wevers has suggested, hospitals don't like cuts any more than anyone else does. But I would have to say, as I suggested

earlier, that our advice to hospitals is to see the ministry. If legitimate hardships are not redressed, we will be the first to join them in making stronger protests. But we do not yet see a pattern of hardships being ignored by the ministry. It's early in the year.

**Mr. Conway:** Thank you very much, gentlemen, and thank you, Mr. Chairman.

**Mr. Breagh:** I have a number of questions. First, the main concern I have is the relationship between your association and the ministry. I must say it's been aggravated somewhat by your early comments today.

It has been my impression that that relationship is somewhat of an old-boy relationship, very friendly. It is unique in the sense that when this government proposes legislation or policy changes in other areas, the process of consultation is quite formal. The positions of those who would be affected by policy changes or new legislation is often very sharp and direct; in terms of labour laws it certainly is; in terms of community and social services legislation or policies. Everyone knows the identifiable groups; they respond in a formal way. The positions are clearly drawn.

With the OHA and the OMA and several other groups in the medical field, those positions are never very formally drawn. One might criticize your group and others involved in the provision of medical services for not drawing the positions clearly.

This is compounded by the fact that, time and again, we get local hospital boards talking to, I am sure, almost every member in this committee, saying, "We have some serious problems we want you to raise in the Legislature, but don't ask us to come in and substantiate those problems. Here is the problem, but don't use my name." They are crying for an occasion to come before this committee with the serious problem they have not been able to negotiate their way out of with the ministry, but when the opportunity is presented for them to attend then they back off saying, "Well, you must remember that if we go today and appear before a committee of the Legislature and lay out our problems and our complaints, that committee will not be sitting tomorrow. Tomorrow we'll have to go back to the ministry and see if we can get more funds and other programs approved."

It strikes me that there is a serious problem in the relationship. You said, for example, initially, you don't know where the bed-ratio formula came from. I can assure you that if that were the size of truck tires out there, the industry would be represented firmly,

in writing, with the ministry, and would be part and parcel of the consultation process in a very formal way. Why have we arrived at this kind of a relationship, as an example—and I ask you just to speak for your own association—between your group and the ministry, which seems unusual in Ontario politics?

**Mr. Wevers:** It is your statement, Mr. Breagh, not ours. We don't believe that that's the situation.

**Mr. Breagh:** So you have put forward, as an association, an official position paper and made your position clear on the current government policies.

**Mr. Wevers:** We speak to the ministry regularly.

**Mr. Breagh:** That isn't what I asked you.

**Mr. Hay:** We put a formal paper before the Elgie committee, very recently.

**Mr. Breagh:** Last year. Have you made a formal position known on the guidelines announced by the ministry on January 19, as an association?

**Mr. Hay:** We talk at formal liaison meetings to the minister.

**Mr. Wevers:** If you mean, do we make a formal protest in our newspapers and try to do something in public, no, we don't. We learned that the best way to get along with government institutions is to live with them, and to make the possible—

**Mr. Breagh:** I don't mean to be critical but I do mean to point out—

**Mr. Wevers:** But your statement is highly critical.

**Mr. Breagh:** Yes, and I think it is a reasonable position for me to take.

In every other area of policy on the part of this government or any government, the accepted procedure is that among those dealing in that field—professionals, whether they run a company, or unions representing those employees—there is not a reluctance to state the formal position of an association or a bargaining group or whatever. Those positions are made clearly and not just to the minister, but to all members of the House. There is a very difficult problem in dealing with medical matters, because of the approach used that no one, virtually no one, is prepared to state publicly a position. Privately, yes. But in public, no. They assume the approach that you have taken, as the one that all should take: that this should be worked out in consultation with the minister and the mechanisms for that to happen are in place. It poses a very serious prob-



lem for me, as an opposition critic, when that doesn't happen.

**Mr. Wevers:** Yes, that could be. I mean that's your political problem, not mine.

**Mr. Breaugh:** I appreciate your sympathy and I intend to return it. Could I continue? I want to ask some specific questions now.

We have had some difficulty with the statements made by the ministry in January—whether or not those were understood, and various problems. So I want to go against a statement that was made very recently, this Monday in fact, in the committee with the Minister of Health present, providing the committee with an overview.

Are you aware that the minister began his statement by saying there are four main thrusts in new ministerial policy to de-emphasize acute hospital care: a long-range plan; greater emphasis on disease prevention in community health programs; third, encouraging increased personal responsibility for health, and fourth, a continued decentralization of planning for health care?

Are you aware of any details of any of those major policy initiatives?

**Mr. Wevers:** No, I am not.

**Mr. Breaugh:** You are not?

**Mr. Hay:** Disease prevention—would you include in that the minister's current stress on immunization? The current program on which I believe quite a lot of money—is that the kind of answer you want for that one? That is something very recent. Personal responsibility; and the last one was detailed local plans, decentralization—

[2:30]

**Mr. Breaugh:** Yes. The minister said, "The fourth major thrust of my ministry's program." What concerns me is that inherent in this, because he used the word "program," is that there is a carefully thought out set of aims, objectives, a program in detail to accomplish something. For example, he says: "My ministry's program is continued decentralization of planning for health care."

**Mr. Wevers:** I don't particularly carry a brief for what the minister said, because it's new to me. I presume what he is talking about there is this regional level of district health councils. I presume this is what he's talking about. I don't really know.

**Mr. Hay:** Twenty-three of them across the province.

**Mr. Breaugh:** But you don't really know?

**Mr. Hay:** —involving local people, advising the ministry upon health matters.

**Mr. Breaugh:** Let me go on because there are other matters, specific ones, that I wish

to raise with you. I know that you have a time problem.

The minister said: "In summary, this policy of de-emphasis of active treatment inpatient care and increasing the provision of alternatives is founded upon therapeutic and economic grounds. It holds the promise of providing more appropriate and less costly care." Have you been involved in discussions on the development of this policy, and do you have the details of how the policy will be implemented?

**Mr. Wevers:** No, we don't.

**Mr. Hay:** We have been involved in talking to the ministry about the de-emphasis on active beds—for over a year. It looked as though it was going to be necessary because of the financial problems.

**Mr. Breaugh:** Do you agree with the minister's statement, and I will quote again: "Today, I think it is clear from our experience that Ontario as a whole is very close to having the right number of beds overall. What is required, however, is a redistribution of beds to achieve a balance in the mix of beds available, so that future needs will be met"? Are you in concurrence with that?

**Mr. Wevers:** Well, I am in concurrence with the latter part of that statement; namely that the mix is not appropriate. That, I am willing to admit, that is: that there are not enough chronic beds. I am not convinced, myself, that active beds are in over supply.

**Mr. Breaugh:** The minister said what we are pursuing is the conversion of active beds so as to provide chronic care facilities in many communities. He also made reference to this conversion program. Are you aware of any conversion program that has been discussed or planned in any detail with you, or anyone else in the health care field?

**Mr. Hay:** I can say that in line with my earlier remarks, those hospitals that have been asked to shut active beds currently occupied by chronic patients, have been approaching the ministry for a solution to the predicament that they find themselves in. One of the alternatives, obviously, is to redesignate that bed a chronic bed and produce a program in the hospital more geared to the needs of chronic patients, than has existed up until now.

**Mr. Breaugh:** Are you aware of a ministry program to—

**Mr. Hay:** That is in line with the ministry, because we have been suggesting to hospitals that they contact the ministry. We know the ministry is receptive in line with this evolving program, to help the hospitals that are in trouble.



If I could go back in the question Mr. Breaugh asked, Mr. Chairman, put to us earlier about what have we done. It was a year ago we had a press conference, which was well attended by the media. It was very well reported in the newspapers, on TV and radio. At that press conference, we alerted the province—not alarmed, we said we were alerting—to the possible impact of the government's deemed intention to reduce active beds: that there would have to be other arrangements made. We took this fuzzy relationship that concerns you—I think it is not really that fuzzy—I think it's just that we don't automatically rush to make releases and file noisy statements.

**Mr. Breaugh:** Some of your statements are a little noisy. Yes. Quite good, in fact.

**Mr. Wevers:** If I might amplify that. I don't like myself going off half-cocked without knowing the details. That's why I refuse to be pressured into making statements, unless I know what I am talking about. I will admit to a certain scepticism, when a program which concerns an institution with which I have long associated, that they are going to be cut back. I am sceptical about whether or not that makes good sense. Before criticizing anyone I would like to know exactly what it is all about. I think we will see more clearly as the budget year goes on. If the minister implements a further reduction next year, as has been announced, then there will be a great deal more screaming, also on the part of OHA, I might say.

**Mr. Breaugh:** It has been put to me, privately, by individual members of hospital boards and administrators, with the caveat that none of this can be used in specific detail publicly, that those hospital boards who attempted to contain their costs, and run the kinds of programs the ministry suggested, have not escaped the restraint program at all; that in fact they now find themselves in a position of having made the cutbacks on their own initiative, over the last three, four or five years, and now are in a worse bind than anybody else. All because they are held under the same restraint program, and not receiving the kind of relief that they need. Would you concur with that?

**Mr. Wevers:** I think that is true. That is in the nature of the case. It is plain mathematics, that if you make an across-the-board kind of increase, it is going to affect every hospital in exactly the same way. If you have been a bit prodigal in spending, and it has been approved somehow in years past, the percentage increase on that is going to be a whole lot better than a hospital that has

lived very frugally. I think there is no possible way in which that could not be true.

**Mr. Breaugh:** Could you—

**Mr. Hay:** Perhaps I should add one thing, if I may, Mr. Chairman.

Anticipating the difficulties that might occur about a year in advance, we approached the Ministry of Health a year ago for a grant to hire consultants, management consultants, to work with us to develop what we call a cost-effectiveness program. I don't know whether you are familiar with it.

**Mr. Breaugh:** Yes.

**Mr. Hay:** As a result of this, we have produced our manuals in a program which we are just beginning to dole out, as we call it, into hospitals, to assist those having troubles. At any point, there are those who reckon they have more troubles than others. These things don't always affect everybody evenly. The cost-effectiveness program is really nothing other than persuading people to admit that when times are tough, we can all do a little bit better. One discovers in each individual institution what the price is. But we have been endeavouring to assist them in a way in which the department heads in the hospitals, not high-priced outside consultants, but the department heads in the administration in the hospital can work together to try to find moneys which they don't need to continue spending the same way; to try to rearrange that in line with the rearrangement of the programs within the hospital.

**Mr. O'Neil:** Do you mind if I ask a question along the line Mr. Breaugh was just asking?

**Mr. Chairman:** I can put you on the list, Mr. O'Neil.

**Mr. O'Neil:** It really relates to just this comment that has been made.

**Mr. Chairman:** If Mr. Breaugh wishes.

**Mr. O'Neil:** Would you mind?

**Mr. Breaugh:** Sure.

**Mr. O'Neil:** The question Mike has just asked was how can you solve that problem that he has just mentioned, where you have had these hospitals cutting back costs over the last few years, then coming back for their grants, and only getting a certain percentage of what they cut it down to? Is there any way we could get the ministry to go back at that, and to reinstate?

**Mr. Wevers:** That is a very difficult question. I don't really know how you can do that.

**Mr. Conway:** While you are pondering that, I had a supplementary, and I would

just like you to consider it. Particularly in light of what the ministry told this committee earlier this week, I have the distinct impression that we have a senior government department which doesn't know, and isn't able to know, which of its subsidiary hospitals is efficient, and which is prodigal.

**Mr. Wevers:** That is part of the problem. I must admit I don't quite know how to deal with that problem. That the problem is there I think you can't possibly deny. There are going to be hospitals that are more efficient than others and have always been more efficient. There are others that have been more prodigal. I know in the past, through line-by-line budgeting and budget reviews with people—the financial people at the ministry—that certain hospitals could have their programs redone. However, to do that for all 250 hospitals, you would have to increase an already huge civil service—at least double it, and I don't think that, with our financial restraints, is responsible either. The answer is I just don't know how to go about that problem, but it is there.

**Mr. Breagh:** Could I put it to you in a slightly different way? It has been put to me by hospital administrators that there isn't a shortage of knowing what to do. There have been substantial reports by the government, by the various medical associations, by those interested in medicine, which indicate clearly what course hospitals could take to cut costs substantially. The problem was put to me by an administrator quite recently. It was very simply this: There was a disincentive to cut out the fat in your system, because if you did that, you wound up with the ironic situation that there was absolutely no good to come out of it—quite possibly, a considerable bad, in the form that a very necessary program you wanted to instigate would go by the boards. So that we have just come out of a period whereby it was a dumb thing for a hospital administrator to cut his costs, because he would pay the price the next year.

**Mr. Wevers:** I am going on record as in full agreement with that statement. It has been the OHA position that incentives towards economy are not built into the program, but that they are only made necessary by across-the-board reductions. This strikes some of us as not necessarily the best way.

It is perfectly true that these incentives are not real. We have urged the ministry that a hospital able to effect certain savings ought to be allowed to retain those savings and put them where best needed. I still believe that is a good idea. The ministry has responded, and I can see some logic in it, though I don't agree with their position. If

the ministry is responsible for overall planning—or let me illustrate. Let's say that in a large metropolitan city like Toronto my hospital effects a saving. The minister responds: "Isn't it up to the ministry to say, if saving in some part of the system can be effected, we should determine where that then should be spent?" Well, there you have two different positions, and I subscribe to the former.

**Mr. Breagh:** Let me pursue one other—

**Mr. Hay:** I just have one further point. We have taken a position that the lack of incentive is a serious disincentive.

**Mr. Breagh:** Yes, yes—

**Mr. Hay:** But in line with what we have been saying, I am sure the members are aware of what happened in Windsor. There, for the first time the ministry said, "If you hospitals will get together and look at what you have too much of, such as"—as I think it was in Windsor—"obstetrical beds, then you may keep the money for neonatal units or extra chronic beds, or whatever you want." We have thanked the minister for doing just what we have been urging him to do, because it has produced the result. The hospitals in that case knew they would have first crack at reassigning the money they could save.

**Mr. Breagh:** Let me ask you about a very specific program. In seven parts of Ontario, there is a chronic home care program with an intent, stated by the minister again on Monday, of expanding this across the province. This is a very noble idea, a concept which I support. What happens to everybody else? If you had chronic home-care programs in place, and someone was occupying an active-treatment bed, or a chronic-care bed in one of your hospitals, and you had a home-care program, it would strike me as a very rational act to say, "You really should not be in this hospital. You can be accommodated, looked after, get better care, much cheaper, at home." You are now in the unfortunate position of having to boot people out of hospitals without chronic-care home programs in most of the province. Is that a supportable notion?

**Mr. Hay:** Booting out?

[2:45]

**Mr. Breagh:** I used the word "booting" selectively.

**Mr. Hay:** I really don't suggest that our members literally boot people out.

**Mr. Breagh:** I'll admit to hyperbole there. I will restate very simply that I know of hospitals where people have been told at



two o'clock that they have to be out by four o'clock.

**Mr. Wevers:** Well, possibly. I am not going to argue specifics. I am not quite clear on this. To me a home-care program is one thing, a chronic-bed situation and a nursing situation are different levels of care. I am not quite sure about shoving somebody out of an active-treatment situation into what you call chronic home care. I am not clear about how that works.

**Mr. Hay:** There are seven programs going at the moment; not just home care, but providing home care for people who are chronically ill. Canada has a reputation for institutionalizing rather a lot of people; be it criminals or be it all sorts of other people, we tend to want to have an institution to put them in.

I think it is interesting to look at other countries where they do have homes for the chronically ill, where four or five are looked after by a house-mother or someone, even though these people might be really quite old. At the moment I am making arrangements to see some of these examples when I am in England very briefly next month. It is something we are just getting into a little more in Canada right now. It has not been necessary up to this point. Everyone in the population, I think all of us, are questioning whether we need everybody institutionalized, and whether there isn't some alternative. It may be at less cost, but anyway, giving the person a better life.

**Mr. Wevers:** If I may supplement this. If what is meant by this, that you should, if at all possible, keep people in their homes, I couldn't agree more. That's the ideal place also for treatment.

**Mr. Breough:** For some.

**Mr. Wevers:** Yes. But that's exactly the point I want to make. As soon as you start the transfer from an active bed immediately to a chronic home-care bed, I'm wondering if that's often appropriate. There is an in-between step. That in-between step is one that has not really been fully thought out, it strikes me, in our system.

**Mr. Breough:** I don't want to leave the impression with you that I, as an opposition critic, disagree with everything the ministry would like to do; I don't.

**Mr. Wevers:** I would hope not: that wouldn't make sense.

**Mr. Breough:** What does concern me rather substantially is that there are different rules for the game in different places in Ontario. In many places I think you can get easy concurrence from me that you have got

somebody in an active-treatment bed in a publicly funded hospital who shouldn't be there. But the bald fact is, there is no place else for them to go. There are no alternatives available.

We can see some very dramatic shifts, say, from the southern part of the province in a large urban centre where there are some alternatives, to places in the north where it is really very crude. You are either in the hospital, or that's it. There's nothing in between.

**Mr. Wevers:** You won't get an argument from us on that. We are only too aware of that.

**Mr. O'Neil:** What do you mean by "in-between place"?

**Mr. Wevers:** There is quite a difference from an active-treatment bed on the one hand, and home care on the other. There are chronic beds for people who really must be institutionalized because they can't take care of themselves.

**Mr. O'Neil:** Are there other suggestions you have besides the chronic bed in a hospital—that in between a chronic-care bed in the hospital and the home there is something else?

**Mr. Wevers:** No, no, not really—

**Mr. O'Neil:** You were talking about having a look at alternatives in England.

**Mr. Hay:** It is a question of matching their particular condition to the kind of bed which is currently available here. In England I understand they do tackle this question of keeping fewer people institutionalized a little more aggressively than some other countries. We think of meals-on-wheels; we think of visiting physiotherapists; we think of visiting homemakers, visiting nurses to make it possible for people to stay at home and out of a hospital bed.

There are ways that this can be organized. I want to try to see if there is anything I can pick up over there to try to help us here in Ontario.

**Mr. Breough:** Could I ask you gentlemen about another very specific concept? That is about what the minister on Monday reiterated, this notion of placement co-ordination services. We have documented, as best we can in the House, the rather tragic circumstances that happen from time to time. Even here in Toronto, with all the facilities available, of the ambulance that makes a trip to three different hospitals and winds up at the wrong one anyway. It appears obvious that there is a need for some co-ordination.

Particularly if the Windsor model is used across Ontario, there definitely will have to



be somebody in place co-ordinating where these people are taken for care. That is a pretty thorny proposition to put to anybody. The extreme of that is there will be somebody sitting in an office somewhere, probably with a computer, pushing buttons saying "this patient must go there." If he doesn't fit there, he doesn't go anywhere.

Are you aware of any real thrust, other than initial studies and guidelines to help councils, that will make it apparent to you that this placement co-ordination service is in the foreseeable future?

**Mr. Hay:** Mr. Chairman, there has been for some years a placement service operating in Hamilton. You may know of it. No program is ideal, but we believe this is going a long way towards putting people in the right bed at the right time. However, people's conditions change. Just because one has a placement service doesn't necessarily assure one at all times that people will be in the right bed.

We have been recently led to believe that guidelines are shortly coming out to help the provision of placement services in other communities. We are encouraged by this.

**Mr. Breagh:** Part of my problem is, if I may use a specific example again, that many people in my area, who are war veterans, think of Sunnybrook as the veterans' hospital. That is despite the fact that for some time now it has not really been a veterans' hospital. Only certain segments of the hospital are for veterans.

**Mr. Hay:** Don't close the veterans' parts; some of us may still want it.

**Mr. Breagh:** My problem is that I have a difficult time talking to my constituents and saying, "Listen, just because you're a vet doesn't mean you have to go to Sunnybrook. You can go to Oshawa General, Ajax, or a number of other places." We have not been successful in communicating to the public that there is a set way to go about this—why it is used for certain purposes and not for others. They are still entrenched in the notion that Sunnybrook is the vets' hospital: "If I am a vet and I am sick, I go to Sunnybrook."

In other parts of the province, someone might say, "I want to go to the Hotel Dieu; I don't want to go to the General," or, "I want to go to the General; I don't want to go to the Hotel Dieu." From the professional standpoint, this placement co-ordination service might be a workable notion, even in the foreseeable future. From the public's perception, I think we are looking at substantive problems. I am not sure that the ministry, the hospitals, or even people like me,

have done very much to even begin that process. It strikes me that it is going to take some time.

**Mr. Hay:** I am sorry, I took the question the wrong way. I thought you meant that once people were in an active bed, for example, if they had an acute form of illness, there would be a placement service to get them moved to a chronic-care hospital or nursing home or convalescent home. That is the kind of placement service that I believe is working in Hamilton and the ministry is working on.

It is not a matter of whether, when I am sick, I go to Sunnybrook, to Toronto General Hospital or to the Brockville General, et cetera. We all know that that is governed by many features: your doctor's preference, your doctor's opinion as to where you will get the best treatment. Furthermore, he may be your family physician, but you may have a condition he believes you are suffering from, so you move to a specialist who then admits you to a hospital out of your community, because it is not too common. Therefore, you have to go where the skill is. I don't regard that as placement so much as the necessities of treating you for more active illness, the placement being for chronic, rehabilitative or convalescent care.

That is not the solution. It is hard to work it, but we are tackling it and supporting it all we can.

**Mr. Breagh:** I have another very specific problem. The minister suggested on Monday as follows: "We know there is a limit below which they cannot function effectually as viable institutions." He is talking about small hospitals. He implies here that there is some clearly defined limit. My experience in visiting small hospitals is that their version of a limit of a viable unit has got to be far different from the ministry's.

In effect, what they're saying is the minister isn't just imposing a restraint program on our little 18-bed hospital, he's effectively putting us out of business. And all the mechanisms that he is suggesting about bed reductions are all nonsense for us. We can't close down a floor because we've only got one floor. We can't make the emergency ward smaller because, physically, there is a constraint and that's all the equipment that's in there. We can't cut back staff because we only have one nurse on. It's one or none. We can't cut back on doctors because there are only two in town. They can't work 24-hour shifts seven days a week.

Have you ever, as an association, attempted to design a model for a small, rural, northern Ontario kind of hospital? Something

that makes the distinction between it being a hospital and a hotel with medical staff in attendance?

**Mr. Hay:** In answer to the question, no. We've never designed a model but we know there are, in Ontario, all sorts of different models. I must say, none of our members has yet said to us that the ministry put him out of business and will we help him, with the possible exception of when Mr. Miller, when Minister of Health, believed it necessary to shut some hospitals. But as an alternative, if you're suggesting that the ministry has so constrained some hospitals now, so shut the tap that the small one's can't operate, they have not come to us yet. Certainly, a lot of what you say about how, if you've got two people in the kitchen you can't lay off a third, is very useful. There are all sorts of complications in a small hospital like that.

I think small hospitals are examining their roles, looking at the job they're doing in relation to the way medicine is practised and, we believe, there will be more of this as people endeavour to match the dollars for care with the needs of the people. We also, of course, know the problems in the north are very real because the distances are so much greater and people have to make provision for services in a certain size of hospital up there which would not necessarily have to be provided down here because you don't get the very bad snowstorms, the very long distances, the blocked roads, and it's a little easier.

**Mr. Breagh:** If I might draw this distinction, it is my opinion that when Mr. Miller, in his version of a restraint program, went on his excursion around Ontario, at least from a central theoretical point of view, the government decided on some economic model for viability and said that if you're below this line, you're out. It was nice and clear.

The current program is nothing like that whatsoever, but what I am finding in visiting very small hospitals is that they're saying, "That's it." He may not be closing this hospital but he is taking away facilities and putting on a restraint program which, in effect, means exactly the same thing, that the two doctors in town aren't going to take that any more. One of them is going and that means the hospital closes. There must be, for example I noticed in discussions yesterday with both Wingham and Goderich, Wingham in particular, that the minister used the words "health service organization" which I'm sure about 25 people in the province understand. There's a hospital board that didn't understand what it was or how they would crank

that up or how it would get started. Would an HSO be different from the hospital they're now running? It strikes me there is a need to find some middle ground and some central agreement on what makes a hospital. What makes it different from a nursing home?

**Mr. Wevers:** What you're saying highlights a real problem, and that is exactly the one that you're outlining. There is quite a distinction between a small, rural 20- or 25-bed hospital in a small community with possibly two doctors, and a large urban centre. I don't think you can treat them the same way. We are working with the ministry because we don't agree that you can treat them in the same way and try to get some change in an approach to the small hospitals. I hope that it becomes effective.

**Mr. Hay:** Small hospitals have received some extra consideration not geared to funding but it's because of the worries of small hospitals and I think, also, the concern of the ministry and the minister that the small hospital is getting worried. That is why we're working with the ministry to mount this small hospital conference with heavy input from him and the ministry in September.

[3:00]

**Mr. Breagh:** This really takes me right back to the beginning of my questions. In the north in particular, and in rural Ontario, that's where I have found administrators saying, "It might be all well and good for Etobicoke General, or Scarborough, or a lot of metropolitan hospitals to deal with the ministry in that kind of a relationship, in which if you've got a problem, you go down to Queen's Park and sort it out. It's half an hour away. You've got three people on staff who can deal with numbers as well as the ministry staff. You've got a board that has friends in the government," to put it as politely as I can. It's quite a rational approach to say that you should tell your members, "If you've got a problem, take your individual problem down to Queen's Park, negotiate it and sort it out."

What I found in the north and in rural Ontario is that it's just the opposite. They're saying, "We'll send our boys down there to try to talk to them. That's something else and we've tried that once or twice and we can't quite compete in that league. We know our stuff about our hospital, but they can take us around the block in a hurry about numbers and statistics and promises that were made by the minister." Wingham was an example yesterday. There is a clear distinction between their impression with the meeting of the minister in his office, and the followup letter that came from ministry staff



to the hospital board. They say: "The minister told us this, but the staff says that. Are we supposed to go back down tomorrow?"

That's a big deal for somebody from rural Ontario; to gather up the board and the administrator—not your administrative staff—and go down to Toronto to compete with the big guns. It strikes me that your approach might be quite eminently sensible, reasonable and rational for certain hospitals in Ontario. For others, it's not a workable proposal for them. They can't do it on that basis and they need a collective organization to function on their behalf.

**Mr. Hay:** That is why for years we've had small hospital conferences to discuss the problems that they have; which have been part of the regular OHA year activity.

**Mr. Breagh:** Could I just finish on this one note? I'm beginning to evolve now, in my own mind, the concept of where the ministry wants to go with the provision of health care. Some of it I see as being quite a rationalization of the approach.

**Mr. Hay:** Quite "a rational" or "irrational"?

**Mr. Breagh:** I said "a rational." It's a slip of the tongue, but I'll leave it in.

I don't disagree that there are people in hospital beds in Ontario who shouldn't be there. They should be in a different kind of bed. They should be getting different kind of treatment. But I don't see the program that's going to get us there. I frankly, to put it as bluntly as I can, see a lot of very high-priced help flying by the seat of their pants. That disturbs me no end. It wouldn't bother me if we were talking about tires, rocks, or how we paint the roads. But when we talk about health care that's a different fish. It goes to the central part of the problem that all governments have in trying to restrain health care. It is very tough to have the doctors say, "You cut our costs and you're killing people". There aren't very many doctors who put it in that language but the inference is always there.

My problem basically is this. I don't see how we get from where we are to where we might want to be. I don't see the program in place. I don't see the mechanisms to get us there. I see a lot of fierce negotiation going on back and forth. Some boards can do that and some can't. They may fall by the wayside. I don't think we should allow that to happen.

In the end, I am a little concerned. For example, in the Windsor agreement which is being touted as a model, not all the hospitals in Windsor agreed to that agreement. Not all of them are party to that. The other one is now off to court, but I don't know whether

that was the reasonable thing to do. That poses to me some problems. What I am concerned with is what happens at the end of all this. I really am beginning to have some difficulties about that as well.

I understand that in a theoretical and rational provision of health-care services, you're not going to please everybody. But I am concerned if they're saying "This hospital, especially in an urban setting, is going to deliver the babies. This one over here is going to be nothing but a chronic-care hospital. This one over here is going to have nothing but active-treatment beds. This one over here is going to have all the top surgeons in town." There are some problems in that, even though it might be a very rational economic model to use. I have been in chronic-care hospitals. They're not the most pleasant place in the world to be. It is that mix of human beings and different approaches to medicine and different concepts which makes for the good provision of health care. Especially when these models get huge, as they do in urban centres, I'm not sure that that's even a desirable aim. I wonder if you would share any of those concepts?

**Mr. Wevers:** I have my problems, too.

**Mr. Ramsay:** Mr. Chairman, perhaps I might be playing right into Mr. Breagh's hands when I make this opening comment—

**Mr. Breagh:** Go ahead, Russ, you are in good hands—

**Mr. Ramsay:** —relative to his old-boy network reference. I would like to throw in a partisan comment and mention that our Progressive Conservative candidate in Sault Ste. Marie was a predecessor of yours, Professor Wevers—Mr. Cunningham—and before Mr. Breagh or Mr. Conway interject he did finish third behind the New Democrats and the Liberals.

**Mr. Wevers:** I noticed that.

**Mr. Breagh:** We assumed that's what would happen.

**Mr. Wevers:** Mr. Chairman, does this merit a reply from us?

**Mr. Chairman:** If you wish, professor, yes.

**Mr. Wevers:** Well, we have a very high regard for Gordon Cunningham. Had he been in my riding, regardless of party I'd have voted for him. We're very fond of him.

**Mr. Ramsay:** My point was that Mr. Cunningham is probably our most outstanding citizen, and his work on the Ontario Hospital Association was done at considerable personal sacrifice. He was away from his practice for days of each week. Therefore I can under-



stand the sacrifices that you're making in fulfilling the role that you are. Having said all of that, I'd like to ask you and Mr. Hay if you have had an opportunity to read the statement that the minister made at the beginning on Monday of these hearings?

**Mr. Wevers:** I haven't seen it, no.

**Mr. Ramsay:** There's a marked difference of opinion on the intent of the contents of this document. My impression was that Mr. Timbrell attempted—and I think successfully—to rationalize the change in the philosophy towards health care in this province. I'm wondering if your association recognizes that changes are needed in the health care delivery service in Ontario.

**Mr. Wevers:** I'd like to make my comments; divide them into two parts. In the first place, I think that in Ontario, we have developed quite a fine health care system. But there are a lot of problems. Like Topsy, it just grew, in large part. Much of this, I suppose, came in when the insurance came in, and we got universal health care. That created quite a bit of growth in the hospital field. Some of it wasn't as well planned as it ought to have been. I understand what was said by Mr. Timbrell, that we have to have some kind of balance in the system; I think that's correct.

There has been a tremendous stress just on hospital beds, active-treatment beds, and so on. There's little doubt that many active-treatment beds are wrongly used, and ought to be used rather differently. I don't want to associate myself with everything that Mr. Timbrell says, because we argue a great deal. However, I think that's just intelligent, that we have to make some changes in the system. What concerns me is, if they are just made by fiat.

They do need very careful thought. I am a little worried about a system in which change is done sort of across the board. What may work, say in Hamilton, may not work in a small town 50 miles to the north of it, where the population index is different.

**Mr. Ramsay:** That observation was made several times yesterday, yes.

**Mr. Wevers:** I'm sorry to be so trite about it, but it seems to me that probably the reason it was made yesterday is that it's true.

**Mr. Ramsay:** It's a commonly-held impression. I wrote down here what I feel are my personal thoughts about the health system in the province. They're just summed up in two sentences. One, I feel we've been faced over the past number of years with

runaway health costs. Something had to be done about it, whether it was pleasant or not. These are personal observations and I'd like your opinions of them. The second thing is that I'm not sure we can go much further than we are at present going. Those are the two observations I'd like to make. I was wondering what you gentlemen think of those thoughts.

**Mr. Wevers:** I'm really very old-fashioned in this. But I still think that if you have \$1 income, you mustn't spend more than \$1. Any kind of government, I don't care at what level, that spends more than it gets in, does not make sense. I know this isn't good modern economics. If in that context you say there are runaway health costs I agree with you because we're running into debt in this province. As I understand it, we have a large debt and that isn't a good idea. I don't think the proportion of our cost for health compared to our total income is all that runaway. If you compare the health cost with the gross national—

**Mr. Chairman:** GNP. Gross provincial product, GPP.

**Mr. Wevers:** Okay, GPP, whatever it is.

**Mr. Conway:** Sounds like a pension plan.

**Mr. Wevers:** It does, doesn't it?

**Mr. Kennedy:** In a way, it is.

**Mr. Wevers:** But I don't think that the proportion, compared with other parts of the world, is still runaway. But then that's a different matter.

**Mr. Ramsay:** Excuse me, Mr. Hay was waving madly behind you while I made that statement.

**Mr. Wevers:** He's got statistics and I'll let him talk when I'm finished. It isn't often that I can pull rank over Mr. Hay and I rather enjoy it sometimes. But on the second point, I agree with you. I don't think that we can turn the screws very much more.

**Mr. Ramsay:** Before Mr. Hay responds, can I give you an idea or an illustration of what I mean by runaway health costs? I use Sault Ste. Marie as an example. We have two excellent hospitals and they've managed to live within the constraints of the ministry. They haven't had to ask for concessions from the ministry. They've had good relations with them, and they've been able to conform.

However, what bothers me is that one hospital will open an excellent cardiac-care service and the other hospital, right next door to it, will open an equally fine cardiac-care service. Somebody will buy a \$150,000 piece of equipment for the lab in one hos-

pital. The other hospital will buy exactly the same piece of equipment. The two pieces of equipment will operate at about 25 per cent capacity each, for a total of 50 per cent, for the community where one piece of equipment could have handled it all, not only for the community but the surrounding area of Wawa, Blind River and you name it.

We have empire-building going on in our hospitals. And this is great in one respect. It means because we do have competitive administrators, we may get a service in a community like Sault Ste. Marie faster than we would normally get it. But because one hospital shows initiative and gets a renal dialysis unit, that doesn't mean the other hospital has to do the same thing. And that's what I mean by runaway health costs, duplicate health costs.

I know our hospitals finally, through the district health council in Sault Ste. Marie, have been told that they have to have a role study and have to get involved in shared services. We've been told that for 15 years, as Mr. Hay well knows. But now we're being forced into it, and I think it's overdue. It's a point being made rather forcibly now by the ministry and one that we have to address ourselves to. That's where the citizen in this province is getting taken for a ride on his health-care dollar.

After I've made that little speech, I wonder if you or Mr. Hay would like to comment on that.

[3:15]

Mr. Wevers: I would like to comment on that. The extreme illustration used there is an illustration of where I think government planning is necessary. I think the role of the government ought to be fairly clearly defined in a democratic state. It should only plan those things which the individual institution can't plan. When the government starts interfering in the work of the individual institution, it's the business of the citizen to scream and yell bloody murder.

Incidentally, I don't believe the situation you were describing is real any more. It was at one time—but no hospital can get by with that today because the ministry will not approve—and I think correctly—that kind of waste.

Mr. Ramsay: I agree, sir, but they were approving it.

Mr. Wevers: You're talking about 10 years ago.

Mr. Ramsay: No—well, I won't argue that point.

Mr. Wevers: Okay, five. I'm not really interested in history. By and by, that isn't real

history anyhow. As a Near-Eastern specialist, I don't admit the term "history" for anything that is AD. That's just modern chronicling. In this modern chronicling, I'm not really interested in—

Mr. Breough: You don't consider Oshawa as the Near East then, eh?

Mr. Wevers: No.

Mr. Breough: I do.

Mr. Wevers: Seriously, that kind of thing shouldn't be allowed, of course not. You can't have two renal dialysis right next to each other when only one is necessary in a community. That's a waste of money, of course it is.

Mr. Ramsay: That didn't happen in the Sault.

Mr. Wevers: I'm glad to hear that.

Mr. Ramsay: No, but there was an attempt to have it happen. We still have that situation with laboratory equipment in Sault Ste. Marie. We still have it today. That's why I believe in the role of the health council, because it has been able to do a better job, I think, than the ministry has been able to do in halting some of this.

Mr. Kennedy: May I ask something? Does this mean that in a situation where this is curtailed, doctors would then, in effect, have to practise within two hospitals? Does this cause administrative problems?

Mr. Wevers: Occasionally. In reality, it doesn't cause tremendous problems. If you have only one of the two hospitals, as in your colleague's illustration, with a renal dialysis unit, obviously the specialist urologist is not going to practise in the one that doesn't have it.

Mr. Kennedy: No, but he may have other patients than those in the one he is basically identified with. Is there free movement?

Mr. Wevers: Not necessarily, no.

Mr. Kennedy: Does the profession have any problems? It seems to me that you have to be accepted by the profession into a hospital to enable you to practise.

Mr. Wevers: No, by the hospital. The hospital grants the privileges, not the profession.

Mr. Kennedy: So in effect they grant privileges—

Mr. Wevers: They may; it's perfectly possible.

Mr. Kennedy: —but there is no problem.

Mr. Wevers: I don't think it's a real problem, no. I don't really think so.



**Mr. Ramsay:** Let me just make another comment in that respect and it will lead up to my fifth and second-last question. Using Sault Ste. Marie as an illustration again; we are sharing services or about to share services, so that the obstetrics are all going to one hospital, the pediatrics are going to another hospital, and psychiatry is coming to one hospital, et cetera. It's my understanding—and I stand to be corrected on this—that the savings that will result from this will be retained by the hospitals. Mr. Hay said earlier that he favours incentives that would let the hospitals retain money they had saved. I thought the ministry was already doing that.

**Mr. Hay:** I wonder if I could comment. It has refused to allow hospitals to keep savings. It has talked in some places of letting them keep half. It has talked in some places and at some times of letting them keep the other half if the ministry thought they should. We have said all the time, just like Mr. Breaugh: "When there is a lack of incentive, when there is, in fact, a disincentive, when you cannot profit from your extra efficiency, then let's rest on the oars. Don't let's worry."

As to your examples of duplication, the ministry has a very simple way of dealing with that and has had for a while. They will not depreciate the equipment in the accounts. If you spend \$10,000 on whatever, and if it is accepted for depreciation, all right, you get that back over a number of years to buy the next one, or buy a portion of the next one. The next one always costs more. When you don't get that depreciation, it makes you think very carefully, unless you're particularly well off for some reason, but then you wouldn't buy the equipment.

I don't think, if you use uncontrolled costs in that sense, it's a problem now. Uncontrolled costs generally, and in the way it would be taken by most people who hear the expression—even the Legislature's own committee, the Elgie committee, blew that one away. It just flatly said that it recognized there were no runaway costs. I don't want to rework that path with the committee, because I'm sure it is more familiar with Dr. Elgie's committee's finding than I am.

**Mr. Conway:** I remember it well.

**Mr. Ramsay:** Mr. Hay, I would be delighted to be proved wrong. I have been out of the health care field for the past four or five years. But I certainly had the feeling when I was in it that we were in the eye of a hurricane on many occasions.

**Mr. Hay:** Going back, I think we have to take a look at history—what I call history. When hospitals were started, most of those in Ontario were started by interested laypeople or sisters, and two hospitals in a community competed. If one got an X-ray unit, the other one did the same. This was to the benefit of patients. Ontario profited from the competition, and let no one think anything else. They also found the money.

But, came the day in 1959 when the government got heavily involved in it, the situation changed, because the cost of everything went up. No longer can we allow this competition. We all recognize that. Therefore, co-operation is the game. The voluntary trustees, who initially brought the hospitals into being, and who have guided them ever since, in attempting to see that they provided the care necessary, are still at it. They adjusted when the government came in and said: "We'll give your hospital its approved costs." They are adjusting now from the competitive phase to the co-operative phase. All over the province there are numerous examples of hospitals getting together to do the very things which you say are necessary.

**Mr. Ramsay:** It has taken them a long time to come to the point.

**Mr. Hay:** It may have, but not that long, you know.

**Mr. Ramsay:** I sat on a joint hospitals advisory committee for years and years and years.

**Mr. Hay:** With Gordon?

**Mr. Ramsay:** With Gordon. I recruited him as chairman. It took us about six years before we made the first major breakthrough. That was to get a boiler system to serve the two hospitals. That was the first breakthrough. Nevertheless—that's being parochial.

I have one final question. Perhaps it is a two-part question. You answered it partially, Mr. Hay, when you referred to the cost-effectiveness program that the association has developed. I was wondering what your association has done to assist the membership in support of efforts to reduce costs? You partially answered that when you mentioned your cost-effectiveness program. I also wonder what steps your association has taken to ensure maintenance of quality of patient care, during this rather trying period we're going through.

**Mr. Hay:** Let me take the second part: quality of care. We developed what we call a concurrent nursing audit program. From time to time one hears that nursing care given in institutions is less than it was. These things are very hard to document. But we developed,



with the assistance of nursing people, a concurrent nursing audit, so that hospitals, if they use it, can watch what's going on. If somebody questions or challenges the nursing care now, versus that of six months ago, they have ways in which they can look back and say: "Yes, it has," or "No, it hasn't," rather than scratching their heads and looking for the answer because no one had really documented what happened six months ago.

What else have we done besides this cost-effectiveness program? For some time, we have helped hospitals to negotiate prices that reflect the strength of their total order, what we call a hospital purchasing program. For some time we have helped hospitals save money in insurance—fire insurance, liability insurance, pressure vessel insurance—and this has had a significant effect in bringing down rates.

We have a group life scheme which we have developed. We started it in 1962 as a way of helping hospitals because at that point hospitals were paying very different rates for life insurance. Since we developed our group life plan, we have now got about 75,000 people covered at about \$1.4 billion of life insurance in effect at very competitive rates.

We have a drug formulary program—a computerized program to help hospitals reduce their drug inventories, which is very expensive, as I am sure you know from your familiarity with the field. It's very expensive if every doctor is encouraged and permitted to stock every drug of his choice. With a committee of the medical staff in hospitals, they develop a listing of drugs, a drug formulary, and we do printouts and computerize it and then print it out and make it pocket sized so that physicians or the staff of a hospital can use it. The government's own psychiatric hospital system uses this. We did one formulary for them for all the psychiatric hospitals some years ago. We have other programs which we are working on all the time to help hospitals get a better value for the dollars they are spending.

**Mr. Ramsay:** Thank you very much, Mr. Hay and Professor Wevers. I found our discussion very interesting and enlightening. I would like, Mr. Chairman, to just table one point that perhaps we could ask the ministry officials to come back on—the matter of incentives. Do the hospitals retain the moneys that they are going to save or will it go back into the ministry coffers? There seems to be a difference of opinion on that point and it seemed to me that Mr. Timbrell had stated on Monday the hospitals would retain these savings. Dr. Dyer said that also so I would like to have some clarification on that point.

**Mr. Wevers:** I can tell you exactly what the situation is. Yes, the hospital can retain, what is it, half, isn't it?

**Mr. Hay:** The latest version.

**Mr. Wevers:** The latest version is that they can retain half in order to fund an approved—that's the \$64 question—an approved program that they don't have, on condition that it will not increase the budget. In other words, there are so many qualifications that for all practical purposes you can't keep a cent. That has been my view.

**Mr. Hay:** It means 50 cents on the dollar might be kept by the ministry.

**Mr. Wevers:** On those conditions. That's an already approved program so it has to go through the district health council and all of that beforehand. Usually they are not large enough so that it would fund a program anyhow and secondly that it wouldn't increase the budget. Of course if you add a program, it is always going to increase your budget so you really are licked before you start on that—

**Mr. Ramsay:** Professor Wevers, I don't doubt what you are saying for a moment but it's a different impression from what I got from the minister on Monday and therefore I would like to have it clarified by him or by one of his senior officials.

**Mr. Wevers:** Right, by all means.

**Mr. Conway:** I presume there have been a lot of versions in the recent past from your perspective?

**Mr. Hay:** There was no sharing of the savings as we recounted to the committee. Then there was this version of 50 cents. Then there is the Windsor experiment where now, in line with what we have been pushing for some time with the ministry as the minister, I am sure, will tell you, we believe the hospitals should be able to profit from their own industry.

**Mr. Rowe:** Mr. Chairman, on a point of clarification, it was my understanding that if a hospital switched from active beds, the expensive active-treatment beds, and created, shall we say, chronic-care beds, that's when the savings would be saved to help accomplish this rationalization program. Is that not right?

**Mr. Kennedy:** It still amounts to dollars.

**Mr. Hay:** If there is a chronic patient in an active bed right now, it won't really vary the costs very much. You just rename the bed.

**Mr. Wevers:** That's the problem.

**Mr. Hay:** Their demand for service doesn't change very much. It's their demand for care.

**Mr. Wevers:** But the allowance, the theoretical allowance for a chronic bed is considerably less than for an active bed. That's correct. But you just put another tag on the bed, it isn't going to change the actual cost.

**Mr. Rowe:** The only way that savings could be accomplished would be by reduction in staff or something like that because chronic beds—

**Mr. Wevers:** That's right. You would have to do a whole floor.

**Mr. Hay:** A totally chronic hospital doesn't need an operating room, et cetera, but you have got to get to that point.  
[3:30]

**Mr. Sweeney:** I have one supplementary question, Mr. Chairman. Mr. Hay, I gather that when the minister announced the Windsor formula, as you just described it, it was to be the pattern of things to come. You seem to suggest this is a unique exception and it's not necessarily the pattern. Could you help me?

**Mr. Hay:** We tried to explain that the current position is the hospital, under certain conditions, gets first crack at half the savings.

**Mr. Sweeney:** No, excuse me. As I understand Windsor, it's not one hospital, it's a total system.

**Mr. Hay:** I know, but the government at one point said if you save, it just goes into the hopper, as Professor Wevers explained. It will go out, maybe to you or someone else, in the system, wherever it's needed. Then they moved and said, with Management Board approval or something, you will now keep half. But consistently throughout, to the minister, commissions, committees and the council of health, we have been saying, without the incentive or removal of the disincentive, you won't really get hospitals trying to save money because they don't profit from it.

The first example of recognition of that was, in our view, the Windsor experiment. The minister has said more than once to the Windsor people, "You want things you haven't got. We in the ministry believe we have too much of certain things". I believe surgical beds was one, and paediatrics another. He also said, "If you get together and rearrange the cards and come up with savings, you can use that money to provide Windsor with services it didn't have before." That, we believe, is an eminently fair approach.

**Mr. Sweeney:** Okay, but the essence of my question is: Do you understand that that

particular approach is now the model in other areas?

**Mr. Hay:** Universal approach. No, no. We therefore urge you to get after the minister to make it the universal approach.

**Mr. Chairman:** That's the point of it all. That's the key question.

**Mr. Ramsay:** Mr. Kennedy has pointed out the statement made by Mr. Timbrell on Monday. I'd like to read it just for the benefit of Professor Wevers and Mr. Hay. This is where I got the impression, "If a community can generate savings from rationalization of services, then the ministry is prepared to act on the advice of the district health council with regard to using the savings to assist in the development of other needed programs in the community."

**Mr. Hay:** That could or could not be what we're talking about.

**Mr. McClellan:** Let me just follow that up with a short reference to the January 19 statement.

**Mr. Kennedy:** I think I'm next on the list.

**Mr. Chairman:** Yes, Mr. Kennedy.

**Mr. Kennedy:** I just had a few questions that are really supplementary. Mr. Breaugh has gone but I wonder if his opening remarks suggest a war between the ministry and the OHA.

**Mr. Wevers:** We are not prepared to take on the ministry.

**Mr. Kennedy:** You're not prepared to engage in battle. What is the relationship? I don't mean to put leading questions, but is it open and approachable and do you have any trouble in liaison? Whether you agree or not is another matter. Just how do you get along, how do you hit it off?

**Mr. Wevers:** Well, I think we're completely frank with each other. At times these exchanges can be fairly sharp. We don't mince words. We believe, and have discovered, that in practice that's the best way to do it. We aren't most effective in our approach by washing our linen in public. We get further by going to the ministry and talking with them. The relationship is, on the whole, quite good. It is one of independent institutions legally incorporated to do their business, responsible for everything that happens there over against the funding agency.

That kind of relationship brings certain overtones with it, doesn't it? You can't avoid that. On the whole I think we find that when we are quite frank with each other it pays off. I think we can speak quite freely with the other ministry. No problems that way. No problems worth speaking to. We



can work them out. We are not going to take them on, and I don't think they want to take us on, so we get along quite well.

**Mr. Hay:** Mr. Wevers has described it correctly, but in my years with OHA, about 12, I worked with eight ministers, and they were all different and they were all a challenge to gain for our members what we believe they must have. I think they take it the same way. We love all the ministers in turn.

**Mr. Breaugh:** That is our concern exactly.

**Mr. Hay:** We have some we love more.

**Mr. Kennedy:** What about liaison with the profession? Again, I presume you talk to the ministry, you talk to the medical OMA, the medical profession. These are, I presume, ongoing, frank discussions of mutual problems.

**Mr. Wevers:** Yes. We don't always agree, of course, because our points of view are different, but we have to live with them; after all, they practise in our hospitals, and in the end we are interested in the same thing, the health and recovery of patients.

**Mr. Kennedy:** Do you feel there is any significant way, or any significant need, to try to improve this relationship, or is it as near as the phone, sort of thing, that you have got there?

**Mr. Wevers:** On the whole, I think yes. Of course, our points of view are different, and I needn't outline them for you, but there are times that we think, "Oh, why don't these rascals do this sort of thing?" and so on, but on the whole we find that we can talk to them. We don't always agree on things, but—

**Mr. Kennedy:** Thank you. There are just a couple of other questions that follow along. You were speaking of the chronic-care hospital, the chronic-care program. We had Wingham and Goderich hospitals in yesterday. Wingham said they were not interested in chronic beds. Goderich said, "Most definitely, we are." In each instance there was to be a shift, if I can use that term. I don't think it quite applies.

**Mr. Chairman:** Mr. Kennedy, I should just correct that statement. Wingham is interested in chronic beds. I don't want the impression to be left that Wingham isn't interested in chronic beds. Indeed, they are. They have had 18 and they have had another seven designated, for a total of 25. They have, according to them, had a chronic-care program and will be beefing that program up. So I just put that on the record.

**Mr. Kennedy:** Well, it was a specific question asked, Mr. Chairman. You are certainly running a tight ship this afternoon, but if we reread the scripture, we will see that they said something to the effect, "Not those five chronic, we want five active beds."

**Mr. Chairman:** They want to keep all their beds, and whether they do it with chronic or active—

**Mr. Kennedy:** Whose riding is that hospital in?

This was really the point I wanted to get at. They also said, "The reason we are not 'so interested'—maybe I can use that terminology—"in the chronic beds in our community is we have a very good program of convalescent or home care." My question is, if we are attempting some standardization or shifting, is there a variation between communities in the availability?

**Mr. Wevers:** I think I have already indicated my own point of view on that, and that is that you can't treat all communities the same way, that to a certain extent the community itself ought to determine what its proper mix of health care ought to be.

**Mr. Kennedy:** I couldn't agree with you more.

**Mr. Wevers:** I don't believe, and the ministry is quite clear on this point, that this sort of fixing of four beds per thousand, or whatever the number, is reality in every instance, in every situation. It is really more than just a creation in order to effect something. Maybe it is a good thing. I am not going to argue that point. But the reality is that that is the actual need for active beds in a community. I find that difficult to swallow from the point of view of health-care needs. From the point of view of budget, yes. That may well be all we can afford and, if so, we as loyal citizens are going to live by it. But no one can convince me that that one is one that can be defended medically.

**Mr. Kennedy:** So the mix of beds could vary according to the monetary situation.

**Mr. Wevers:** But many political decisions are based on monetary considerations, I'm sure. At least, that's the way—

**Mr. Kennedy:** Just one final question. District health councils have been developed over a number of years. What are your observations on their effectiveness? Could you give us your comments on them?

**Mr. Breaugh:** I didn't write these questions. He thought them up on his own.

**Mr. Kennedy:** I'll reread your testimony, Michael.



**Mr. Hay:** District health councils were the subject of a resolution at our last annual meeting, and the membership asked the ministry for the annual budget of the district health councils and its opinion of their effectiveness, and some of the good things that they've brought about.

**Mr. Kennedy:** I'm sorry, you said that the OHA, by resolution, was going to ask this question of the ministry.

**Mr. Hay:** No, we asked it, the membership asked it of the ministry at our annual meeting last November.

**Mr. O'Neil:** What's your opinion of health councils?

**Mr. Kennedy:** Yes, that was my question.

**Mr. Hay:** They are not all the same. They are trying to understand their role as advisers to government. And as the gentleman from the Sault mentioned earlier, they are now helping in the Sault and other places to advise the ministry.

We certainly do not agree that they should run any health services. We don't think that's their role at all. They're very interested in the community. They're trying to do the same job the chairman of the district health council did in Windsor. He was the guy who sat at the end of the table, as I understand it, with the hospitals around, saying "Now gentlemen, we have a problem." Our honest broker is trying to make the deal between the hospitals, as the evolution of the hospital system continues to take place.

We think that district health councils have a role in helping the ministry. But we can see that time is against consulting district health councils in every situation, simply because they don't have a staff of experts. Heaven forbid we have 23 mini-ministries. That would be quite horrific. Obviously there are times when the minister and the ministry cannot consult them. There isn't time for the district health councils to get beefed up on the situation.

**Mr. Kennedy:** In Peel—

**Mr. Wevers:** Potentially they make sense. Community planning, where the community decides what ought to be, is evidence that that can happen. Mr. Hay has delineated the Windsor thing, the example that's usually trotted out. Ideally, I think, that's the way it ought to happen. It's simply another level of bureaucracy that the poor hospital has to go through in order to get any place. That's another potential danger. I'm not saying it's realized, that's for others to say, but it's another kind of danger. I suspect that both patterns can be evidenced in the province, I'm sure.

**Mr. Cooke:** I keep hearing "Windsor" and I can't help but remember all the problems that resulted before the final plan. I'm sure you're aware that the ministry originally told the district health council to close Riverview Hospital. They told them to close some obstetric wards. They told them to do this, they told them to do that. All the hospitals were in a state of chaos. It didn't run quite as smoothly as it may have appeared to people who aren't aware of the Windsor situation. The district health council, for about two years, was used as a whipping boy in the ministry.

**Mr. Kennedy:** Has it smoothed out now?

**Mr. Cooke:** It's been smoothed out now to some extent but certainly not to the point you may think it has. One of the hospitals yesterday went into court, because they're not satisfied with the cutbacks and what's happening. They're taking the ministry to court.

[3:45]

**Mr. Hay:** We're absolutely against the ministry attempting to use district health councils as just a block between them and the hospitals. I mean, that's another level of bureaucracy, and at one point there seemed to be a feeling that the ministry was itself saying "yes", when the answer was "yes, but going through a district health council" and the answer was "no," which we didn't like either.

**Mr. Kennedy:** In Peel-Halton, we've established one. It started and sputtered a bit at the start. But we're in a growth situation, where there are new hospitals on the books somewhere down the road. In this respect it seems to have pulled various interested parties together. In that situation it's quite different from the Windsor one.

**Mr. Wevers:** The potential of a district health council working beautifully in a growth situation is of course much larger than in the reverse situation. But then anything will work in a growth situation, too. As you know, if there's expansion, there's lots of money. It's very easy to plan. But it's when the planning goes the other way, and you've got to pull back somewhat, that it's much more difficult, and I feel kind of sorry for one of these. I wouldn't serve on one of those things for all the rice in China.

**Mr. Kennedy:** We know about declining enrolment in the schools, too.

**Mr. Wevers:** It's the same kind of problem, isn't it?

**Mr. McClellan:** Mr. Chairman, I'll try to be brief. I realize the time constraints. Mr. Hay, I'm an avid reader of your—

**Mr. Hay:** FYI?

**Mr. McClellan:** —newsletter, yes. I wanted to ask you a couple of questions about material that has been presented to us through the vehicle of the newsletter, perhaps for some updated data or updated reaction to comments that you made earlier in the winter. In the newsletter of January 17 you expressed concern about the impending budget constraints and dealt with the question of Ontario's active-treatment bed ratio, and I'll quote from your newsletter: "Ontario already has, by the ministry's own admission to the Elgie committee, the lowest bed-population ratio of any province except Newfoundland. Our own calculations indicate that it's 4.37 per 1,000. Ontario's ratio is, in fact, already the lowest in Canada." Perhaps I should simply ask you if you would provide to the committee at a subsequent date your own calculations of respective bed ratios for each of the provinces.

**Mr. Hay:** For all the other provinces?

**Mr. McClellan:** Including Ontario.

**Mr. Hay:** They're straight available government statistics.

**Mr. McClellan:** You're using ministry figures when you say 4.37 per 1,000.

**Mr. Hay:** It might be—

**Mr. McClellan:** What are your figures? Just provide us with what you have.

**Mr. Wevers:** Even beds—

**Mr. McClellan:** It would be helpful simply to have as a document for the committee. You went on to say in the same newsletter that you were feeling a great deal of concern about the deficit position of hospitals. The heading of the sub-column is "Hospitals in the Red" and indicated that you were doing a survey of non-teaching hospitals outside Metropolitan Toronto, which on the basis of partial returns, I gather to a questionnaire, had determined that out of 128 hospitals that have so far responded, more than one third expect to finish the current year's operations with a deficit.

"That's alarming enough," quoting from your newsletter, "but the prospect is even worse for 1979-80 based on assumptions of a 4.5 per cent, budget increase in the ministry and cost increases for labour, supplies and other components ranging from six to eight per cent. Only 10 of the 128 hospitals expect to be able to break even. That's fewer than eight per cent." Can you give us an update on that survey? Do you have returns from additional hospitals?

**Mr. Hay:** No; now it's sort of old hat. The year has ended. That financial year has ended and we haven't got the information yet about the settlements that hospitals have had with the ministry, which would either confirm or dispute, confirm or not confirm their forecast made earlier. I'm sorry, I have no other information now.

**Mr. Wevers:** I have only one piece of information. The hospital that I represent is \$15,000 short. That's the only one I know.

**Mr. McClellan:** Are you dealing now just with the anticipation or are you dealing with—

For which fiscal year? I didn't quite follow your response.

**Mr. Hay:** You're referring also to a teaching hospital, I think, where they have looked ahead to the next year. Yes, that's right.

**Mr. McClellan:** Are you expecting to get more returns from that survey?

**Mr. Hay:** We carry out these surveys from time to time to get an update, but we haven't got one going on at the moment. We're waiting until we believe the—

**Mr. McClellan:** What was total sample of the survey?

**Mr. Hay:** That survey that you referred to was 128; 128 had reported. Yes, well, the total survey was all hospitals except those in Metro.

**Mr. McClellan:** Is that a normal return rate?

**Mr. Hay:** Oh, that was only at a certain point in time. Heavens, no, we do better than that. But that was just at that point. It's 120 out of about 200—a fair sample at that point to speak to.

**Mr. McClellan:** Do you expect to hear from the remainder?

**Mr. Wevers:** We'll get complete statements back on year-ends.

**Mr. Hay:** But it takes time. Not everybody fills forms in equally quickly.

**Mr. Wevers:** And you don't get the settlements for quite some time, for budget year-end, until after the events.

**Mr. McClellan:** When do you expect to know, of that group of 200 hospitals? When do you expect to know what the total deficit position is with respect to 1978-79?

**Mr. Hay:** When all the year-end settlements have been completed with the government and every hospital knows its own position. Some point after that, when they tell us, we'll know.

**Mr. McClellan:** And, just guessing, when would that be?

**Mr. Hay:** I wouldn't know. They could, of course, get the settlement for six or eight months, rather than at the end of the financial year.

**Mr. Wevers:** It'll take 10 months after the end of the budget year before we know what happened provincially.

**Mr. McClellan:** Do you expect that ratio of 33 per cent of the hospitals being in a deficit position to hold through the rest of the sample?

**Mr. Hay:** I couldn't say. I hope to God it'll be better, but I don't know.

**Mr. McClellan:** Is that consistent with the returns of previous years, or is that unusual?

**Mr. Hay:** No. Ontario hospitals have, I think, a very creditable record of keeping in the black—unlike some provinces. In some provinces, hospitals have been in the red much more readily than any in Ontario.

**Mr. McClellan:** So that this is an unusual finding. In your words, I think, startling.

**Mr. Wevers:** Yes, that's right.

**Mr. McClellan:** And less than 10 per cent of the hospitals anticipated that they would be able to break even in 1979-80.

**Mr. Hay:** That's right. Hopefully, that will turn out to be gloomier than reality, but it's going to be a while before we know that.

**Mr. McClellan:** Why do you say "hopefully"?

**Mr. Hay:** Hopefully it'll be gloomy. Because it will mean that more hospitals than that have got adequate money.

**Mr. McClellan:** What is the basis for your optimism? Or is it just a wish?

**Mr. Hay:** I don't know what these hospitals thought might happen in labour settlements at the time after the AIB period—what these hospitals felt labour settlements would be post-AIB. They obviously had put in some things—God knows what they are. And I don't know how they compare with what is being freely negotiated now. So if we're negotiating at higher figures than they expected, we can both agree, I guess, that there will be a worse experience than expected. But if it's not so bad, then the reverse.

**Mr. McClellan:** Has anything that the ministry has said subsequent to January 19 caused you to have more optimism that a higher percentage of your hospitals will

escape fiscal 1979-80 without a deficit position?

**Mr. Hay:** No, I think that, as we said about an hour and a half ago when we were talking about the advice we're giving to hospitals, if you really ask, go and see the ministry. We know the talk's going on and hopefully out of this will come additional moneys to help those that can't get by with what they've been told they're going to have now.

**Mr. McClellan:** In other words, we both shrunk.

**Mr. Hay:** Hope springs eternal in the human breast.

**Mr. McClellan:** I share your hope. I don't know that I can express very much optimism on the basis of what I've seen.

In your newsletter of February 14, you note that you asked the minister and his senior officials at the Sheraton Centre meeting on January 19 if hospitals could be told the population they serve by ministry calculation. You go on to say that nothing has been produced yet. You go on to recall what you call the regression analysis charade.

**Mr. Hay:** Debacle.

**Mr. McClellan:** "Charade" was the word you used. "Debacle" is equally appropriate. Have you had any success, as an association, getting those base figures from the Ministry of Health?

**Mr. Hay:** The ministry gave us a demonstration of how they had developed these figures at one of our meetings. They used the Brantford area as an example. We listened with interest and retired to consider the figures they'd given us. We noticed there seemed to be about 15,000 Indians on a reservation that had been missed in the calculation. I believe they're looking into that.

**Mr. McClellan:** This was only on the Brantford figures.

**Mr. Hay:** They were the example they gave us. They did give us a whole lot of other figures for the province.

**Mr. McClellan:** Brantford is the only one that you've actually analysed.

**Mr. Hay:** That was the example that they used.

**Mr. Wevers:** We haven't got the other population figures, no.

**Mr. McClellan:** So I take it you still have the same concern you had in February. You don't know what the starting figures are, in terms of initial calculations.



**Mr. Wevers:** We would rather do our own adding, just to see whether it adds up to the population of the province. I mean, we don't doubt anybody, but we'd still like to do our own, for fun.

**Mr. McClellan:** Do you think the ministry has these figures?

**Mr. Hay:** Oh yes, they have given us some more figures. We're less concerned than we were.

**Mr. McClellan:** What figures have they given you?

**Mr. Hay:** They've given us a population figure for Ontario and we haven't yet tied them all in. I think they have them tied in. We had a very sincere concern at the time it was written. It's lessened now.

**Mr. McClellan:** I may share with you the disconcerting fact that we have been unable to get these figures.

**Mr. Hay:** Oh, that's interesting.

**Mr. McClellan:** May I ask you, is this a bulky document that was provided to you?

**Mr. Hay:** They did give us quite a bulky document. I must admit I haven't looked at the whole thing. But they also gave us a summary of the population breakdown developed by TEIGA. Does that mean anything?

**Mr. McClellan:** In the interest of time, what I'll do is ask our research people to get in touch with you to get the title of the document provided to you. If you could give us a copy of the summary, we can then pursue this elusive material with ministry officials.

Just one final 30-second-or-less question. In your January 31 newsletter, again talking about the specifics of the budget constraints, you express a concern, based on immediate reaction of hospital people, that the real dollar constraints would probably force many hospitals to reduce beds below the new guideline figures, in order to stay solvent. Can you bring us up to date as to whether you have had more communication from hospitals with respect to that particular concern? [4:00]

**Mr. Hay:** No, we can't give you the result of any survey, but I repeat what we have said before. To every hospital that comes to us with sincere concern about how they're going to get by, we advise them to see the ministry and if they get no redress to get back to us.

**Mr. McClellan:** How many have done that so far?

**Mr. Hay:** I don't know how many. They've not only phoned me in the place. Certainly we haven't had anybody back yet saying

that they have given up that route. No one has told us yet that they feel they are completely happy with it.

**Mr. Chairman:** Thank you very much, gentlemen. Your association performs a very important role in the hospital field and therefore members have been most interested in your views and that's why we've kept you longer than we originally intended. Thank you very much.

Next we have Dr. Irvine and Dr. Robinson from the Meaford General Hospital.

**Dr. Irvine:** Mr. Chairman we have a fairly lengthy brief prepared and we have copies available for the committee.

**Mr. Chairman:** We'll see that those are distributed. I understand you had the minister up to your hospital last night?

**Dr. Irvine:** Yes. We heard the same story you heard Monday.

**Mr. Chairman:** So then in short, nothing was resolved?

**Dr. Irvine:** No. It was a very smooth meeting and a very nice supper and the population was kept in control.

Mr. Chairman and members of this committee, we are physicians from the Meaford Medical Society.

**Mr. Sweeney:** Excuse me. Before you begin could you help me to understand what area you serve?

**Dr. Irvine:** Meaford General Hospital is our main base and we serve the area between Collingwood township, Euphrasia, Meaford, Thornbury and Clarksburg, between Owen Sound and Collingwood, and the Beaver Valley.

**Mr. Sweeney:** All right, I know the area.

**Dr. Irvine:** We met with the minister, Dennis Timbrell, on April 9 and presented a brief which came about from problems existing in the local hospital.

Meaford General is a 50-bed, active-treatment hospital with 15 chronic beds and we have an active emergency department. This also acts as an outpatient department. We serve the areas of Meaford, Thornbury, Clarksburg and the townships of St. Vincent, Euphrasia and Collingwood. The static population is around 13,000 and during the summer and winter seasons we go up by about 10,000 to 12,000. We have recently been designated as a four-season resort area.

Meaford is a very isolated catchment area, being about 50 kilometres from Owen Sound and about 30 kilometres from Collingwood. Owen Sound is our main referral centre. There are more specialists there at the main general hospital, and Collingwood supplies

only basic medical care as ourselves. Meaford lies in the snow belt and is isolated from Owen Sound and Collingwood several times a year because of snow.

We supply medical, surgical, obstetrical, paediatric, outpatient and emergency services, with a vast increase in orthopaedic services in the past five years due to a new orthopaedic surgeon coming in. We have a new orthopaedic surgeon who is supplying services in our hospital. The orthopaedic service cares for the majority of problems in the Blue Mountain and Beaver Valley ski resorts. The emergency department is increasing in activity due to the increase in tourism since the four-season designation has occurred.

We feel that due to the proximity to the ski hills and being on a main tourist route, together with periodic isolation in winter, the hospital is an essential facility in our community.

We feel that fiscal restraints are producing conditions at our hospital where bed reduction is the only way to live within our budget. We feel that in our present financially troubled world we should live within guidelines, but feel that the budgetary restraints should not be used as a weapon to produce political aims, namely bed closures. We feel the implementation of such programs should be managed by people on the spot, and not dictated by a faceless bureaucracy.

Thornbury and Clarksburg, with a total population of around 2,000, have recently become the site of a geriatric nursing pilot project, focusing attention on the fact that we have a higher aged population than exists provincially. This has been protested in the past by both our local district health council and the Ministry of Health.

A recent Statistics Canada population study shows that Thornbury has the second highest geriatric population in Ontario with a 24 per cent figure. Our experience in attempting to gain reference figures from the ministry to compare with Statistics Canada figures has shown variations of more than 50 per cent in our populations. The referral population statistics used by the Ministry of Health have succeeded in confusing many people involved in looking at these figures.

The statistics used in arriving at bed numbers at our hospital in two studies, namely, the bed study report by the Grey-Bruce District Health Council and the proposed 3.5 per 1,000 figures by the ministry, indicate several conflicting facts. The DHC figures at 5.4:1,000 show a three-bed overage for our referral population. The Ministry of Health figures at 4:1,000 referral population show an overage of eight beds. The district health

council study was made by a reputable company with Ministry of Health support in funding and data supply.

It appears to our society that vast amounts of time and effort are being spent on studies and projections which appear to be based on incorrect data or misinterpreted data. We contend that if this effort was spent in observing cost-efficient facilities functioning, the unique nature of small general hospitals would become more apparent to our mandarins.

Meaford General Hospital was involved in the Grey-Bruce District Health Council bed study report and was assessed as a cost-efficient hospital with no apparent overuse of beds, but which appeared to be operating on a low base budget.

The initial impact of financial restraints occurred five years ago when we were in the midst of expanding our outpatient, emergency and chronic-care facilities. Our budget was frozen at the pre-expansion base. Due to the efforts of our administration and senior nursing staff, we have continued to function at a higher program level than previous to the cuts, but now find that there is no other way to pare our spending programs. If further restraints are necessary, we will have to cut back on programs and staff.

The Ministry of Health has pointed out that 15 to 20 per cent of active beds in Ontario hospitals hold people who are really placement problems. Due to our large geriatric population, we find ourselves with the same statistics, with a chronic placement problem. A recent study, in 1977, shows Grey county deficient in nursing-home and extended-care beds. To our knowledge, the Ministry of Health has not increased licensing of nursing-home beds in Grey county since that time.

Another problem arising with nursing-home placements is the fact that nursing homes are autonomous and have the final say in who is admitted to the facility. This has been a contentious issue locally since a local nursing home has developed a retirement home in continuity and simply feeds the retired into the nursing-home beds when these become available. This is a triumph for private enterprise, but a disaster for our chronic patients. We feel that bringing nursing-home licences into hospital control would delete the spurious use of admitting privileges and allow improvement in general hospital functions, such as average length of stay and occupancy rates.

We have been interested in the 3.5:1,000 referral population guidelines and sought information and reassurances from the Minister of Health that once these were ob-



tained, further depreciation in figures would not occur. We were reassured that 3.5:1,000 is the figure considered optimum by the Minister of Health and that the ministry would have this applied province wide. We were, however, told that if circumstances warranted, certain areas could have this increased, but only if the total provincial average could be maintained by changes in other areas.

This has been discussed with our local district health council, who have adopted the same line of thinking as ourselves, namely, that small hospitals should be looked at as unique settings and dealt with on an individual basis.

Small hospitals have arisen in Ontario due to several factors: (a) increasing population; (b) increasing medical personnel in the area; (c) distance from other centres; and (d) community concern and pride. Most small hospitals in Ontario are functioning efficiently and to the benefit of their patients. We have had repeated episodes where out-of-town people have either commented on the fine service received, or have come back for treatment and followup, despite the fact of long-distance travel, et cetera.

This speaks in itself in showing that the services are at a par with, or better than, larger, more impersonal centres. We do not imply that large centres should be made into groups of small hospitals, but point out that there is a unique service available in smaller centres.

We feel bed closures at our hospital are untenable due to the following:

1. We are cost efficient, patient oriented and in an expanding area.
2. Our base budget is unrealistic, and since our meeting with the Minister of Health, we hope this will be reviewed.
3. We have a 98 per cent occupancy in medicine and surgery and have maintained constant pressure to improve and control utilization involving all departments, medical staff, and board in these exercises.
4. To effect dollar savings at Meaford General Hospital, we would have to close 15 to 18 beds. This would be akin to closing Meaford General Hospital since:

(a) The time spent building X-ray, lab, physio services would be lost by attrition;

(b) The operation would become less cost efficient by having to employ outside lab, X-ray, laundry, dietary sources, et cetera;

(c) Patients would have to wait for admission or be transferred to other centres where no doubt these problems also exist;

(d) Meaford General Hospital is the second largest employer in the area. By destroy-

ing jobs, hardships would increase due to the fact that (1) this is a depressed area, and (2) many employees are one-parent families who are determined to make it on their own without government aid;

(e) We had noted prior to our visit to the Minister of Health a drop in our staff morale. Since then we have had open meetings with our staff who are now in the picture and are as determined as we are not to have Meaford General Hospital altered to its detriment;

(f) We are also beset by patients who are troubled that our community hospital is threatened. Since our meeting with the Ministry of Health, public meetings have been held, and the fact that information has been made available to them has made the public much more supportive of the Meaford General Hospital.

As previously stated, we feel that financial restraints have caused unnecessary programs to wither. The 10-bed buffer for hospitals under 100 beds represents a method of allowing small hospitals some leeway in maintaining basic programs. We have requested that the buffer be maintained and have actively sought support from other hospitals in asking the Ministry of Health to maintain this buffer. Our meeting with the Minister of Health and subsequent contacts suggest that this may be continued. However, last night the Minister of Health would not commit himself that the 10-bed buffer would be maintained.

**Mr. Breagh:** Could I just stop you there? Would you repeat that statement?

**Dr. Irvine:** Last night the Minister of Health was at our hospital's annual meeting, and he was asked a specific question, would the 10-bed buffer be maintained, and he would not comment.

**Mr. Breagh:** He would not comment.

**Dr. Irvine:** He would not comment. He said this is still under advisement and that the matter will be discussed at the September small hospital meeting.

**Mr. Breagh:** If it's any comfort to you, yesterday afternoon ministry officials sat there and said that it was in place until they decide to change it.

**Dr. Irvine:** We feel the 10-bed buffer represents the difference between extreme hardship and maintaining health-care standards and manageable restraints.

If beds are to be closed, then the institution of extended-care nursing-home and domiciliary-care programs should take place prior to closures. The systems in West Germany and Great Britain appear to work in urban centres but certainly would be hard to apply



in rural areas. These systems are paramedical, nursing and paranursing personnel, and, if they are available, no doubt would produce a change in hospital occupancy and costs.

An alternative method similar to home care would involve expensive and not particularly efficient intensive day and night care by Red Cross, VON, practical nurses, et cetera, in a domiciliary setting. In a district as widespread as ours, this would be cost-intensive, with no savings in overall bed costs.

A current study of the Grey-Bruce District Health Council Continuing and Long-Care Committee has proposed as its immediate priorities (1) and a 24-hour non-professional home assistance program, a possible addition to chronic home care; and (2) to examine alternative methods of implementing increased communication and placement co-ordination.

It would appear that our district health council was thinking along the same lines as ourselves and seemed to be pointing to domiciliary care as a positive action in cutting hospital costs and admissions. However, the old problem of cost of building a service, licensing operators and monitoring the system is raised as soon as the possibility of starting this is commenced. There is no doubt that controls of a certain nature would be required but surely a modicum of common sense, compassion and a desire to serve should be the only requirements in this type of service.

In implementing alternative methods of increased placement co-ordination and communication, the very way this is written suggests some central registry, which again raises the ogre of increasing costs and further departments. The recent upheaval caused by the Ministry of Health has certainly improved communication between small hospitals and, if this were nurtured and expanded, the old-boy network could lead to a low-cost co-ordinating system. It would appear that a rigid system of placement management would be unacceptable in the rural setting due to distances to be travelled. If the existing system could be expanded, this may make the solution more acceptable.

These appear to be viable methods of loosening up chronic overutilization in hospitals and show the trend of thinking over country and local hospital levels. We feel that viable alternatives must be available prior to closures.

[4:15]

Improving the utilization of services should lead to cost savings. Studies of bed utilization have shown areas where logical changes in services can be made, thus increasing effi-

ciency and saving costs. The practical application of these systems should be monitored and criteria developed by professionals. The rigid application of utilization criteria, however, will lead and does lead to evasion and prevarication due to resistance to regimentation.

Utilization review is a useful tool in supplying statistics and may allow the study of differing methods of practice. At present, medicine is practised on an individual basis and where it appears that all doctors do the same thing for the same reasons and in the same time span, it is obvious in practising in a small hospital that there are as many methods of practice as there are doctors. The results may be the same and the time of stay, et cetera, may be close, but there is no absolute rigidity in practice, which makes the selection of criteria in peer review and utilization review, if not difficult, provoke some anxiety.

Review of peer review studies in the United States and utilization review studies have shown a wide variety of reactions and show a trend to uniform denigration of the system by the physicians concerned. Personal communications with peers in the United States have suggested that comparing your performance to perhaps the lower one-third performance initially made one feel good, proud, et cetera, but then led to disillusionment since repeat studies showed the results to be exactly the same with no improvement in overall performance.

It would seem, therefore, if peer review is to work, criteria should be set to allow improvement to occur, and if not, some mechanism for producing improvement should be introduced. The implementation of the recent controversial study by the College of Physicians and Surgeons of Ontario of medical competence is at least a step in the right direction, in that suggestions as to improving the areas of practice will be made, and most likely will be followed up by the college.

In private enterprise a successful business makes a profit or fails. In succeeding, it requires to increase productivity and efficiency, increase the end cost of the product, employ fewer people, or reduce duplication or frills. In health care, the cost is borne by the consumer, either by direct payment, insurance premiums or taxes. We are utilizing the last two methods, and it is being suggested that further involvement of direct payment may be necessary.

We feel that our hospital could only be marginally improved in efficiency and that by laying off people our efficiency would suffer. We therefore should look at the frills.

In practice today, large numbers of diagnostic tests are ordered, often in a by-rote fashion, lest some abnormality be missed. If an abnormal result is found that is not related to the specific diagnosis being sought, it may be repeated and/or amplified in an effort to elucidate the process, or the patient may be referred for specialist advice and/or treatment or diagnosis.

Large numbers of normal results are obtained and where these may reassure the patient, it may represent many wasted dollars. Many of these tests have limited value in having wide ranges of normal and the interpretation of the test is left to the discretion and experience of the physician. The routine ordering of such group tests, such as SMA-12, though touted as cost-saving by the lab, is commented on only to point to its compliance with the law of diminishing returns.

We feel that many physicians use their clinical judgement and acumen in ordering tests, but there are often pressures from patients, peers and other groups such as labs which may increase the numbers ordered. We therefore suggest that, through the Ministry of Health physician profiles, a review of lab usage could be carried out and a continuing medical education program on lab utilization could be instituted.

The replication and duplication of very highly specialized units in large hospitals, such as cardiovascular and neurosurgical units, where three or four units may exist in close proximity in a city, suggest an area where overspending is occurring and where utilization may be more than optimum and the product less than expected. No doubt many of these have started through private funding and perhaps this may be an area where private insurance could be introduced if coalescence of these services proved difficult.

The application of the \$9.80 per diem fee in chronic-care facilities appeared like a sensible move. However, the list of exemptions made the income produced negligible. There is no reason why chronic patients should not have their pensions cut, leaving them an allowance. This was applied to welfare patients in the OHIC days with no complaints from the patient. Nowadays, it seems that for most chronic patients the only time they see family members is when the old age pension cheque is available for transmission to the bank or to some family member. We understand the ministry is now re-examining the exemption clauses and offi-

cials think that until now they have been far too lenient.

We suggest the recommendation of the select committee on hospital costs with regard to paying the first day of hospital stay, with a similar fee for outpatient department visits, be re-examined and instituted. Exemptions would no doubt be required, but if this produced eight to 10 per cent of costs this would place the onus on the patient, and relieve the taxpayer of an increase in taxes and/or premiums.

We recommend that OHIP premiums reflect the cost of the service. This is in line with the medical profession and association policies, that the patient be aware of the cost of service and of his liability in the matter. It may be useful to have public hospitals issue patients a copy showing their costs while in hospital so they may know how much their stay has cost and how much liability they bear in maintaining our health services.

Automobile insurance and health insurance originated to provide coverage in the event of some disaster which might wipe out a family's savings, et cetera. Automobile insurance continues in this line, with little complaint from users compared to health insurance users. The application of realistic premiums to cover expected coverage by the consumer, with alternative plans for extended or special risks should be explored.

Perhaps a basic coverage plan could be listed, with add-on units in place of the luxury service which is now taken as being the only possible kind available, and which is costing us dearly. Although we are suggesting participation by the patient, we are all physicians participating in OHIP who in pre-OHIP days supplied the same type of service to our patients with no grasping for returns.

We feel that undue attention has been paid to physicians' fees as a cause of increasing health costs, in light of burgeoning social and welfare programs, increasing ministerial activity and the free drug program, which for instance now supplies ASA and cathartics as well as necessary drugs.

We appreciate this is a good program, and that our patients will be more compliant in taking medications, but perhaps the frills and over-the-counter drugs could be removed, which would make physicians much more comfortable within the system. In a presentation to the Minister of Health we asked for details of the cost of maintaining the ministry and its services. These were not available. However, we were quoted a figure of \$5 for each claim processed. As a vast



majority of these claims will be for office visits worth \$7.70, this would seem to be a rather excessive expenditure.

The current expenditure estimates, 1979-80, volume 4, show an administration budget of \$52 million. These however do not show building costs, or depreciation or any breakdown as to what part of the provincial debt the health budget causes. It is also noted that \$2 million is set aside for advertising and such matters on TV and in pamphlets, et cetera. The impact on health of these methods is not proven. This would appear to be an expensive frill.

In summary, we feel the closure of beds in the small hospitals would be efficiency destructive, poor public relations and dictatorial. Financial restraints may be necessary. However, the elimination of costly replications and frills, and education of the public and health professions may lead to a more satisfactory funding arrangement.

The 10-bed buffer in a small hospital should be maintained. By public education and involvement in realistic premiums or taxation, health dollars will increase to cover the desired level of service. Planning for the future should be at a realistic level of five to seven years, so programs can be carried through, and health personnel can be sure of their continued employment. If the small hospital is to fail many young people have the chore of relocation, which is wasteful of their professional lifetime. Primary location is much easier than continuous movement, with incidental building of practices, et cetera. We feel that hospital cutbacks, by financial restraint and bed closure, is a dangerous process in that these establishments are community property and a source of pride to the staff and the community. Most programs instituted in small hospitals are usually basic, have existed since the inception of the hospital and reflect the capabilities and pride of both physicians and nursing staff. A cut in the service will lead to a loss of pride in service, loss of staff through attrition; and local anger and disturbance, especially if done in a high-handed manner. Whereas most physicians are apolitical in the choice of hospital, et cetera, they would certainly become politically active, and indeed reactionary, if there were any threat to their community hospital.

We feel that the public should pay for what it expects, which is a superior medical and hospital service available in Ontario. If the public is unaware of the cost of the system, then we are all failing our duty to educate them, and should take a look at our motives in not letting our public know the facts.

It also appears that long term planning at the ministry level does not involve active hospital input. The proposed Ministry of Health, OHA and small hospital group meetings may lead to the active involvement of professionals, and some feedback may lead to an improvement in communication. There is no doubt an increase in professional involvement and interest in professional matters, as well as increasing irritation at the lack of communication and participation in hospital decisions made by the Ministry of Health, Minister of Health, or his assistants.

One of our biggest complaints involves faceless bureaucracy, which is their way of explaining the largely dictatorial method in which hospitals and delegations are met and dealt with by ministry assistants, whose positions are not explained and who frequently fall back on ministry policy or on decisions of a higher authority in the ministry when there are questions on figures or data collection methods; or on why certain policies are being followed or maintained.

We are well aware that decisions are made on the knowledge of many facts, and particular expertise is required in equating the needs of various programs. Our contention is that where there is a dispute over program changes, et cetera, then all pertinent details—data used and the names and qualifications of those involved in the decision—should be available so that discussion can take place and dissension can be rooted out at the proper source.

The pilot projects of HSOs are being followed with interest. It was thought the inception of district health councils would have led to the HSO concept earlier. We fail to see what effect decentralizing money control will have in increasing efficiency or utilization. There is a recurrent theme in conversations with regard to planning that the Ministry of Health seems to have no future planning of note, appears to be devoid of ideas of how to get itself out of the current financial problems.

Even allowing for inflationary trends, comparison with PSI and OHIC makes OHIP look like a loser. Perhaps the Minister of Health and Her Majesty's government in Ontario wish to leave the health-care field. If this is the case, it would be better sooner, before bankruptcy and plant deterioration make changes unattractive to other parties.

We feel that health professionals have been unfairly blamed as the cause of current problems. Since both the medical profession and the nursing profession pointed out at the start of the insurance system that the open-ended system would become financially untenable, it therefore comes down to making



the system pay for itself, either by increasing premiums or taxes; or cutting programs to a basic style and letting other parties cover extra charges, either directly or by extra insurance. It would require education of the public and great strength at the political level to do this. The Minister of Health is determined to maintain the program at the current level within his guidelines, so it would appear that the public must be asked for more money, or choose a different system of a different Minister of Health.

Since starting this, we have read and spoken to many people in this same situation; it appears that lack of communication is the one recurring basic complaint, with form letters and rather hard line statements being issued by the ministry. We realize that as departments enlarge the number of personnel increases and the capability for interpersonal communication lessens. We feel the high cost of maintaining this system, however, demands that lines of communication should be kept open; the grassroot listening post would allow decisions that would not appear dictatorial. The lines exist between OHA and the hospitals; they would be open to the ministry with a little effort being expended on both sides.

We have become aware, through experience, that ignorance of the so-called proper channels in a ministry makes for tough sledding in attempts to gain even communication within a ministry. It seems pointless to have MPPs available at the end of the phone, and yet have to make repeated attempts to find the proper bureaucrat to speak to in following up on ideas or questions. I can appreciate that running as large an operation as the Ministry of Health is complex and likely difficult. But we have found that in the private sector, complex businesses pride themselves on the availability of the senior executives for discussion. Perhaps we should be looking at the quality of administration at Queen's Park instead of looking at our own small offices.

In summary, we would stress that small hospitals should be looked at as unique institutions; and further, special note should be made of their efficiency, capability and place in the community. The 10-bed buffer should be maintained, the base budget should be reviewed. Institution of the small hospital-Ministry of Health conference should be pressed, so that feedback from concerned and experienced administration and medical staff would perhaps show where ministry philosophy is wanting, and where leads and changes and programs should be explored.

Public education should take place to reveal what taxes and premiums supply, and

the extent to which deficits are occurring should be made known. Further, the significance of these deficits as far as cutting programs goes should be publicized. A realistic premium system should be applied; exploration of differing types of coverage, similar to auto insurance or life insurance, would at least allow public awareness of what our system is worth.

Financial restraint, though necessary at this time, should not be seen as a political tool but applied with communication and understanding by the ministry.

[4:30]

We would ask that communication lines be opened; and that members of the ministry responsible for decisions be identifiable as responsible for these decisions.

The \$9.80 per diem for chronic patients should be applied; the recommendations of the Elgie committee on paying the first per diem as an inpatient and a similar outpatient fee should be re-examined and instituted.

A review of matters related to our lifestyles, such as smoking and alcohol consumption should be undertaken, and an examination made of the costs that overuse and abuse of these items add to the total cost of health care; perhaps the rolling over of these costs on income from cigarette and liquor taxes to the health budget, or increasing these tax penalties, should be examined.

We would stress again the need for open communication between the field and the ministry, and emphasize that close examination of the data and motives in attempting to change programs should be maintained.

**Mr. Chairman:** Mr. O'Neil.

**Mr. O'Neil:** Mr. Chairman, I could mention to Dr. Irvine that he might possibly find it quite useful to obtain from the clerk's office the minutes of yesterday's meeting here, because we were dealing with closing of two other small hospitals; I think he has drawn attention to some very pertinent facts in his presentation today. I think he would find of interest what was said yesterday by the members. As I say, I think a lot of it would apply to his hospital too.

When the minister attended your meeting last night, did he give you any hope that your base budget might be reviewed?

**Dr. Irvine:** Not specifically; nothing specific came out of the meeting. We had him in our clutches for three hours.

**Mr. O'Neil:** Clutches?

**Dr. Irvine:** He was in our building, he was away from his cohorts. He had a very pleasant time. He met a lot of nice people.

He would not commit himself to state that our financial status would be examined. He would not commit himself to say that the 10-bed buffer would be maintained. He was specifically asked questions after his speech.

**Mr. O'Neil:** You seemed quite critical of ministry staff, and you mentioned just now that he was away from his cohorts; do you feel that you're not getting the answers that you would like?

**Dr. Irvine:** We had a meeting with the minister in April. Since January 19, when the OHA started to question the budget restraints and bed closure policies, there have been a multitude of meetings. We have attempted to attend the ones in our areas. There was a meeting in Walkerton in February where an assistant deputy minister was quoted as saying the 10-bed buffer would be cut as of October of this year. When we met with the minister this was completely turned around. There were several things. A letter which had been sent from our board to the Minister of Health which expressed our concern about the bed closures and the status of the 10-bed buffer was reported as not having been received. At this point, and at various times, we have attempted to call specific people and have had a little bit of a runaround. We feel if we have a problem in our practice with our patients our patients can come to talk to us or we can call back and get them; but we don't have this open-ended conversation available in this situation.

We represent only eight physicians. We represent our hospital board of 20 people active in the community. Since this has started we have been in the public eye; we have gone to the public and we have asked them to write to the Minister of Health, and from what we gather the Minister of Health is receiving a great deal of static from the people who use our hospital. Public support appears to be behind what we are asking for; which is if he must make changes at least give us the time to look at how we can do it. Let us make the changes that would affect our system best, that would make our system fit into what he thinks the perfect hospital would be.

**Mr. O'Neil:** I think one of the points brought out yesterday, and it was gone over again today with the OHA people, was that the hospitals had been required to cut their budgets back and get rid of a lot of the fat. This has been done in your hospital too?

**Dr. Irvine:** We didn't get a chance to cut it back. Ten years ago we started building a new outpatient wing and a new chronic

wing. At the time of the freeze, we were running 15 beds short in the hospital because of the building program. Our budget was frozen at that level so we didn't have the opportunity of cutting back. Now with the new bed status report we're looking at losing 14 beds.

**Mr. O'Neil:** You also commented about health councils. What do you think of health councils?

**Dr. Irvine:** I think health councils, once they mature, will probably become a useful part of health care for a community. It's much the same as electing someone to a trusteeship on a hospital board. You've got to give the fellow time to mature to an understanding of what's going on and finding out what his job is.

Our health council comes basically from rural areas. They're usually farmers. They have no hospital experience; they rely very heavily on one or two interested professionals to guide them. Now in the three years they've been there, they have evolved from a ministry appointed tool to a body more attuned to what the local hospitals are doing and what local hospitals want. They're receiving much more support, and we're receiving support from them now.

**Mr. O'Neil:** I am also interested in your comments about the lack of nursing-home accommodation. What is the alternative accommodation if you have to put them out of the hospital because you don't have room for them?

**Dr. Irvine:** I can't think of anyone on our staff who has discharged a patient from the hospital in those circumstances in the past. I've been there 14 years and I don't think anyone's ever been thrown out of the hospital. We have a problem in the Grey county area. There's a deficiency in nursing-home beds. One of the local nursing homes undertook, when expanding, to build in 10 extra beds, and these have been available since 1977. They have never been used. They have not been licensed.

The same nursing home undertook to expand their area and build a retirement home, which gives the operation continuity using the same services. We find they take the lame and the halt from their retirement home before they'll take a chronic patient from the hospital. We only have two in our area.

**Mr. O'Neil:** I know there are other members who have questions. I would just like to say I think the brief is an excellent one. After some of the meetings we had yesterday and the people we heard from, and then hearing



your brief today, it is our hope the government will re-examine its position on a lot of these smaller hospitals, given the problem they've created for you.

**Mr. Breaugh:** I want to commend you and your colleagues, Dr. Irvine, for doing something it seems few hospital boards, people in the medical profession and anyone connected with the provision of health-care services, have had the guts to do; that is come before this committee and say exactly what you think.

I'm disappointed, frankly, with the representatives from the hospital association who diplomatically stated that it's better to suffer in silence than go see somebody in the ministry on the off-chance the next time you go you at least won't have created any enemies. It really is refreshing to see a group of people who are prepared to state exactly what they see, in language that people can understand.

You did use some strong language in the course of your presentation, and in the written brief you put before the committee. You made reference to dictatorial attitudes and hard-line approaches. You used the words: "If we're going to go out of business anyway, it's better to put them out of business now before bankruptcy and plant deterioration make changes unattractive to other parties." That is certainly expressing the case much more firmly than anybody else who has appeared before the committee.

Are those remarks for purposes of effect, hyperbole, or is that the reality as you see it?

**Dr. Irvine:** You've probably noticed I have an accent. Jokingly, at the meeting with the minister, I was called a refugee from the National Health Service because we asked a specific question. I asked if the National Health Service was coming to Ontario? And 25 per cent of our medical staff are from Great Britain.

I don't think that's strong language at all. I would hope if I had a conversation with you I could speak that way to you; and I certainly spoke the same way to Dennis Timbrell last night because this is something which concerns me very deeply.

This is a community pride thing. It is This is a community pride thing. It's almost a natural thing. This is a threat to something which is dear to a lot of us. We all have our own little enclave, our own little group of people who we are interested in. Our community is our community and we want to persist in maintaining what we have. We have a very basic hospital. There are no frills but the people are happy with it; the

service they get there is first class. We want to maintain that first class service. We don't want to live in an image that might just be fading away because of leaching out of funds.

**Mr. Breaugh:** Could I run through some specific things with you? We just had a presentation, which you sat through, by the Ontario Hospital Association. They made their point of view very clear. It strikes me you are the classic example of someone who has done what they suggested should be done and you come up empty. What are you going to do now?

**Dr. Irvine:** We'll just keep digging.

**Mr. Breaugh:** Do you feel there should have been a presentation on your behalf, representations on behalf of your group and other hospital boards, which the hospital association must know about, to the ministry? Should there have been a formal position put? It would not be unique; they certainly have passed resolutions at previous meetings.

**Dr. Irvine:** I think what has happened in the two months or three months during which we have become involved in this is that the promise there would be a small hospital-OHA-ministry conference has probably prompted a great deal of the anger and the frustration that at last we are going to be able to sit down with X number of people, to speak and explain our position and hear their position. It may well be that this is the situation in which the OHA is holding back any irate members of the association. The OHA represents all the hospitals and there are probably less than 100 hospitals of our size in Ontario.

Our board chairman has communicated with all of these hospitals of the same size and the Minister of Health has received endorsement of our position in a letter that was sent to him by our board chairman voicing support of our position by approximately 50 per cent of these hospital boards.

**Mr. Breaugh:** I must say I find it absolutely amazing that the promise of holding a conference is enough. It sure wouldn't be for me.

**Dr. Irvine:** It may not be for you but—

**Mr. Breaugh:** Have you ever been to one of these conferences before?

**Dr. Irvine:** Sure, yes.

**Mr. Breaugh:** Do you still hope?

**Dr. Irvine:** Well hope springs eternal, as they say, and maybe some day the light will shine.

The whole premise we run on is that the hospital's board of trustees are a bunch of volunteers and they have to be sure what



they say reflects the mandate they have been given by the people who elected them. A lot of these people are changed every two years; they have to mature and become aware of the ramifications of OHA involvement with the hospital. Most hospital trustees think the hospital is run by the administrator, by the nursing supervisor and by the medical staff, and that their involvement in this is purely as an advisory body, and where necessary a supportive body. I think the trustees are becoming a little concerned now that their position is being encroached upon by the ministry; that they are no longer needed. What they see is the start of a National Health Service type of thing, where an executive is placed in a position over them and if they want to come to the meetings, fine.

**Mr. Breaugh:** In your brief, your presentation today, you talked at some length about the communication problem that you are having, particularly with the ministry teams, as I am told they are called, in the field. You are into the classic problems of small hospitals about referral population, what's viable and what is feasible in the cutting of beds. In fact you go so far in your brief as to say that for all intents and purposes they are closing the hospital.

**Dr. Irvine:** Well, if we have to close 18 beds, the 14 beds that they quote, we—

**Dr. Irvine:** Having looked at our figures we couldn't see closing 14 beds as being cost efficient; it would make little difference in the amount of money spent. We would have to close 18 or 20 beds and this would annihilate the nursing staff as well as all the ancillary staff we have built up. We get these people because they want to live where we live. We don't have an employment agency at the doorstep so we have to have some attraction to make sure these people will come and stay.

**Mr. Breaugh:** Have you established what "viability" means for Meaford General Hospital?

**Dr. Irvine:** No, I can't say.

**Mr. Breaugh:** You're not at that stage?

**Dr. Irvine:** There is a constant fluctuation in demands for money from various sectors of the hospital staff. There are union negotiations, which may mean five per cent or may mean 15 per cent. The cost of medical supplies has increased enormously in the last year. Our administrator has to budget and he thinks maybe 10 per cent will cover him. He doesn't know, it may be 20 per cent. Our viability, economically, is certainly not assured if we cut back to that level.

**Mr. Breaugh:** Have you considered hiring consultants to do a management study in your facility, or does that make any sense?

**Dr. Irvine:** This has been discussed at the board level and there is communication with the OHA to see if their management consultants think this would be of any value to us.

**Mr. Breaugh:** You mentioned several times in the brief the problem you have in not being able to project, for planning purposes, the economic growth security of your system. Over a four-, five- or seven-year period. Could you, in some further detail, tell us what ramifications that has for staff, for plant maintenance?

**Dr. Irvine:** We have eight men on staff. Fifty per cent of them, four of them, are under 40. These fellows, if they have to relocate, would find it relatively easy; but it would be extremely difficult for the four fellows over 40 to take their families, move to a new location and try to find another situation. The relocation of nursing and professional staff in another hospital would also be difficult; because this is not an isolated thing, this is happening in every hospital.

**Mr. Breaugh:** You mentioned at some length the local problem of nursing homes, retirement homes, referrals and what not. Have you ever approached the ministry to do any form of chronic home care, to expand the licensing of nursing homes, to see that that need is taken care of in whatever form might be practical on a local basis?

**Dr. Irvine:** This has been handled by the chronic care board of the district health council; they hope, in the near future, to produce some paper that will be instructive to the ministry as to our needs in the area.

**Mr. Breaugh:** How long has your health council been going?

**Dr. Irvine:** Two and a half years, almost three years.

**Mr. Breaugh:** Let me ask you a question I've asked a number of people in various parts of the province much like yours: If you were to name one thing, just one, that the health council has accomplished in its two-and-a-half years of existence, could you do it?

**Dr. Irvine:** Yes.

**Mr. Breaugh:** What?

**Dr. Irvine:** Smartened me up.

**Mr. Breaugh:** Could I just finish off by going through your summary here?

**Mr. Conway:** Excuse me, just what does that mean?

**Dr. Irvine:** It's made me aware of what's going on. It's made me much more aware of my lot in life as a professional in a small hospital. The district health council was dumped on us; it was given to us. The budget for the first year was \$40,000; the budget for the second year was \$80,000; the budget for this year is \$180,000. They've gone from a secretary to an executive director, an assistant executive director, plus the secretary. We're now deluged by second-class mail once a month telling us what the board has done. I'm a member of the district health council.

**Mr. Breaugh:** But aside from that inspirational view—

**Dr. Irvine:** I think they're going to become useful but they have to be allowed to mature. They have to go out and get their spot in the community where they can produce.

**Mr. Breaugh:** I would go so far as to say that your comments are virtually a consensus of opinion from most parts of rural Ontario where there is a district health council. The pattern is extremely similar. It may have had some effect in terms of making professionals in the field aware of particular problems or needs. In some cases it has identified needs; in a few cases it has suggested alternative forms of care. But it's almost universal that in the first two to three years of operation, no one could say that any form of health care has been approved, altered, additional programs run—whatever.

Could I just run down your summary, which strikes me in many respects to be something that ought to be of great concern to the committee? Some of these matters were dealt with by a select committee last year.

First off, I support the notion that you propose, that there needs to be—special category may be the description or at least an accommodation for those hospitals which do not fit the big city norm; that there has got to be some attempt made to provide for the basic hospital unit that is in place all across the north and in rural Ontario.

Even though we are providing an opportunity here for that kind of a situation to at least get an airing, there still seems to be a reluctance on the part of the ministry to admit that, to admit there are differences between the hospitals and that everybody is getting saddled with the same thing.

Could you expound a little bit on the 10-bed buffer? We went through this routine yesterday, as to whether or not the buffer is for this year, until the fall; or is perhaps government policy until it's changed or whatever. It really strikes me that is a bit of a despera-

tion move, even on your part here. I don't see much in any of the other comments that you made that would establish that a 10-bed buffer would do much other than preserve the status quo.

**Dr. Irvine:** The status quo is a thing I guess most community-minded people would like to maintain until they can be shown that the alternatives are going to produce better care.

**Mr. Breaugh:** Fine.

**Dr. Irvine:** I don't believe in standing still if you can make progress, but I don't like climbing up slippery walls if all I am going to do is fall on my face. In applying the 10-bed buffer in a hospital of 50 beds: if the 3.5 per 1,000 figures were applied today our 50 active beds would certainly go to 36. The 10-bed buffer would then raise that up to 46, so we'd have to close four beds; we'd have to deactivate four beds. Which would save no money; there would be no cost saving. There would be constant harping on the part of the medical staff to the supervisors about why the hell can't my grandmother get into that bed because it is lying empty. And the supervisor would say because we don't have the nurse to fill it; and they'd say of, course, there's a nurse sitting there doing nothing.

The fact is that if we cut the beds back by the recommended figures in the 3.5 guidelines, we would have half a nurse in one hall and three quarters of a nurse in another hall. This is the way the hospital is set up, they have to go from one spot to another to work.

So that 10-bed buffer represents a safety factor. It is an allowance that permits us to carry 10 grandmothers that don't quite make it into the chronic wing and don't quite fit into a nursing home or can't quite go home. So they give us a shot at that 10 per cent or 15 per cent chronic placement problem that has been discussed before.

**Mr. Breaugh:** Will you explain a little bit? This would appear at first glance to be one of those places that has been caught with a base budget that was not reasonable. Will you explain that a little bit to the committee?

**Dr. Irvine:** Yes. We were extending our building in 1974. We had received permission to build a new outpatient wing and new chronic wing, to extend the X-ray facilities and the lab facility and physiotherapy. During that time we closed off 15 beds. While we were operating in that condition at that minus-15-bed rate, our budget was frozen—our operating budget. We have never been able to get any movement back on the allowance for those 15 beds.

**Mr. Breaugh:** So in five years of trying you have been unable to get the ministry to



understand there were extenuating circumstances in the base budget for that year.

**Dr. Irvine:** Yes.

**Mr. Breagh:** I see why you are a little concerned about communications.

Could I just finish on this? This conference intrigues me for no other reason than it was finalized and announced the day before or the day when this committee began to sit. If I weren't such a suspicious sort, I might not be able to see a relationship between those two events. What's your expectation of that conference? I mean, do you really want another opportunity to tell the ministry what's right or wrong? You are down here today. You had the minister in your own bailiwick last night. What could a conference do other than have you join 100 or so other hospitals in the same boat? What do you realistically expect out of that?

**Dr. Irvine:** Realistically I hope that the political pressure from the various small hospitals involved will be bearing fruit by that time. The response from the public, the things happening at Windsor, the very fact that people are willing to come and spend time looking at this, and spend time to prepare briefs for it, will at least let the minister know that there is more than just acquiescence in the outside world.

What he is trying to do may appear theoretically very attractive and very possible, but we would like to be shown that this is a practical solution he is trying to bring to us. The one big thing we hope will come from it is that the budgeting system that this committee on resources has been asked to produce will be produced by that time. He has promised and he says a committee of his ministry, of the OHA and the administrators of teaching hospitals, has been asked to produce a formula for base budgeting for small hospitals. We hope this is one of the things that will come out of it.

**Mr. Breagh:** Could I just finish with two quickies? You stated in your brief that you have a 98 per cent occupancy in medicine and surgery. Isn't it kind of dangerous to run at that high a level?

**Dr. Irvine:** We have 115 per cent most of the time. We have beds in the hall.

**Mr. Breagh:** That answers that question. If nothing changes and the ministry does not give you further consideration, and the small hospital conference doesn't do anything, what will happen to Meaford General Hospital two years from now?

**Dr. Irvine:** Hopefully we'll still be there. Hopefully we'll still be fighting. I don't

think the community spirit we have identified will be lost. Various churches and service clubs certainly have shown a great deal of interest. I am quite sure they will pass the hat around and keep the place going.

**Mr. Breagh:** You seem to have identified something we saw yesterday in both Wingham and Goderich. You are at the point where you are really attempting to work out other ways to finance the hospital other than the ministry.

**Mr. Blundy:** I wonder, do your patient-stay days compare favourably with others?

**Dr. Irvine:** The average length of stay is below the mean for the province, for our size of hospital.

**Mr. Blundy:** In my city, people have to wait six or eight weeks to go for elective surgery. Do you have that situation as well?

**Dr. Irvine:** Our waiting period for elective surgery is probably three to four weeks. It's not as long.

**Mr. Blundy:** I know in my city it's not uncommon to have six or seven patients in emergency waiting to get into a hospital bed. Do you have that?

**Dr. Irvine:** We put them in the halls because our emergency service is less than the size of this room. We have to utilize it for operating rooms, and so on.

**Mr. Blundy:** Obviously your hospital is being used to the fullest extent.

**Dr. Irvine:** Yes.

**Mr. Blundy:** Yes. Now, do you really believe that you can convince the ministry that the use it is getting is necessary and you can't get along with less use?

**Dr. Irvine:** We run a very basic hospital, as I have said. There are no frill services in our hospital. Anything that requires high-powered medical care or high-powered surgical care is transferred. We run a very basic program, and I think that a review of our statistics would show we run an efficient hospital. We also run a utilization review committee. We run a medical audit committee so we are aware of what's going on. I mean, we are becoming aware of the types of practice in the hospital. We are still trying to alter these things where necessary.

**Mr. Blundy:** I think you have put up a very good case today, doctor. I hope you continue the fight.

**Mr. Leluk:** Dr. Irvine and Dr. Robinson, you are both members of the medical staff at this Meaford General Hospital?

**Dr. Irvine:** Yes.

**Dr. Robinson:** Yes.



**Mr. Leluk:** As a member of this committee I would have expected to see the administrator of the hospital here today, along with the chairman of the board. Would you know why they are not here today?

**Dr. Irvine:** Yes, this was a representation of the Meaford Medical Society. This is done specifically by the physicians.

**Mr. Leluk:** I noticed the brief was put to the committee by the physicians of the Meaford Medical Society, but I am still somewhat surprised not to see the administrator of the hospital.

**Dr. Irvine:** The board has been extremely active in another political sphere in the last few months.

**Mr. Leluk:** Were the administrator of the hospital and the chairman of the board present at last night's meeting with our minister? They were there?

**Dr. Irvine:** They have both received copies of these briefs. They have been present at discussions on the briefs, and these reflect the board's feelings too.

**Mr. Leluk:** What was the hospital's increase in budget, say, for the 1979-80 year as compared to last year?

**Dr. Irvine:** Four point five.

**Mr. Leluk:** Four point five per cent?

**Dr. Irvine:** Per cent, yes.

**Mr. Leluk:** Was the 10-bed cushion a factor in this increase?

**Dr. Irvine:** The 10-bed cushion just stayed there.

**Mr. Leluk:** In other words, you've lost no beds?

**Dr. Irvine:** We've lost no beds. There have been no penalties assessed against us.

**Mr. Leluk:** Is that really the main concern that you have at your hospital, that that 10-bed cushion be maintained? Does that seem to be the major concern?

**Dr. Irvine:** This is the main concern of the board at present, but if we drop below this, the penalty of \$12,000 per bed per year will then be assessed which the minister has said would be assessed against the hospital if we ran over the bed usage according to the program. We would like to stay within the guidelines. We actively tried to stay within the guidelines, but we have run a deficit of \$8,000 to \$10,000 this year.

**Mr. Leluk:** So you are operating under a deficit budget?

**Dr. Irvine:** Yes.

**Mr. Leluk:** Has your hospital taken any steps to encourage the present trend towards alternatives to hospital care and, say, outpatient surgery? Are you doing anything in these lines?

**Dr. Irvine:** We have an active outpatient surgical service. A great number of the orthopaedic procedures which used to be done as inpatients are done as outpatients. A great number of diagnostic things that used to be admitted are being done on an outpatient basis and there has been utilization review. It's started. It's by no means showing great numbers of things that should be changed in the medical practice in our hospital. But the medical staff has activated utilization review and audit.

**Mr. Leluk:** I was out of the room very briefly and I think Mr. Breaugh asked this question, but I didn't hear the complete answer and I'd like to ask the question again.

Have you or your board considered engaging the services of management consultants to review the operation at your hospital?

**Dr. Irvine:** I believe the board has made representation to the OHA to have this set up.

**Mr. Leluk:** To the Ontario Hospital Association?

**Dr. Irvine:** Yes; and have some access to their management.

**Mr. Leluk:** And during your meeting with the minister last night, were there any discussions on the possible conversion of active-treatment beds to chronic beds?

**Dr. Irvine:** This was discussed also in April when we were down at the ministry, and during the conversation about this the conversion of active beds to chronic beds was discussed. It was also pointed out that he expected no saving in funds because of this, and we couldn't quite see that the alteration of a name tag with no possible saving of funds would have made any difference to the utilization of the hospital.

**Mr. Leluk:** I would think there would be a saving in the long term. I take it then — my next suggestion might be out of line — in other words, you have not submitted any kind of formal proposal, say, to your district health council?

**Dr. Irvine:** This is being investigated at present by the DHC.

**Mr. Leluk:** Your district health council is investigating it?

**Dr. Irvine:** They are involved in chronic care and—

**Mr. Leluk:** But has your board made any formal representation to them, say, for the conversion of your active-treatment beds?

**Dr. Irvine:** Not at the moment. We are awaiting the outcome of the Chesley and the Durham setup. They are at present investigating. Chesley has asked to have certain beds changed and Durham has asked to have certain beds changed, and I believe the ministry and the DHC are discussing this at present.

**Mr. Leluk:** I believe the minister did indicate to you last evening that he didn't intend to continue to hold open discussions with you regarding your concerns and what have you.

**Dr. Irvine:** Oh yes.

**Mr. Ramsay:** Mr. Chairman, my questions have all basically been asked and answered.

As a closing comment, I was impressed by the brief, as other members of this committee have indicated they were. I was particularly interested in the fact that you didn't deal on a completely parochial basis as to the problems in Meaford, but expressed some concerns about the health-care delivery service in the province as a whole. In fact, some of your thoughts might not get ready acceptance in every area, such as items five and six: public education, what their taxes and premiums supply, and what deficits are occurring, should occur, and the significance of these deficits as far as cutting programs should be publicized—I agree completely.

You also state in number six that a realistic premium system should be applied. Exploration of differing types of coverage, similar to auto insurance or life insurance, would at least allow public awareness of what our

system is worth. You might have some trouble selling that one to everybody.

I note you also mention the \$9.80 per diem for chronic patients should be applied, and the recommendations of the Krever committee of paying the first per diem as an inpatient and a similar outpatient fee should be re-examined and instituted. I understand that was studied in a committee similar to this and it was agreed upon, but now there seem to be a lot of second thoughts on that matter. Item 10, of course, makes an awful lot of sense.

I was very interested in reading your brief—not just listening to the problems in Meaford but some of your thoughts overall on the problems we are experiencing in Ontario. Thank you very much.

**Mr. Chairman:** Thank you very much, gentlemen, for coming down and attending. We appreciate your views and the points which have been raised in the brief, as Mr. Ramsay and others have indicated. Thank you very kindly.

The committee is adjourned until Monday next, June 4.

**Mr. Breagh:** Could we get as quickly as possible a day-by-day list as to who is coming when?

**Clerk of the Committee:** On Monday, we think the Etobicoke General is going to come.

**Mr. Breagh:** And who else?

**Clerk of the Committee:** Tuesday, Scarborough General, and Wednesday, OPSEU. But there are some people who said they are going to call back.

The committee adjourned at 5:07 p.m.

## SPEAKERS IN THIS ISSUE

Blundy, P. (Sarnia L)

Breagh, M. (Oshawa NDP)

Conway, S. (Renfrew North L)

Gaunt, M.; Chairman (Huron-Bruce L)

Kennedy, R. D. (Mississauga South PC)

Leluk, N. G. (York West PC)

McClellan, R. (Bellwoods NDP)

O'Neil, H. (Quinte L)

Ramsay, R. H. (Sault Ste. Marie PC)

Rowe, R. D. (Northumberland PC)

Sweeney, J. (Kitchener-Wilmot L)

**From the Ontario Hospital Association:**

Hay, R. A., Executive Director

Wevers, J. W., President

**From Meaford General Hospital:**

Irvine, Dr. I. F., Head of Medical Staff

Robinson, Dr. D. C., Member of Medical Staff



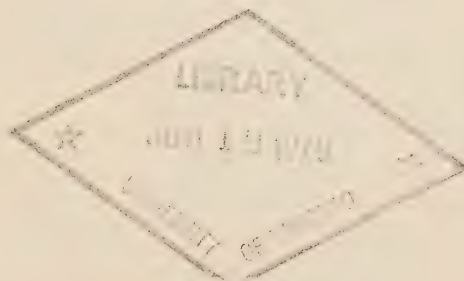
No. S-21

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Monday, June 4, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.

Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

MONDAY, JUNE 4, 1979

The committee met at 3:42 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Chairman:** I call the meeting to order.

This afternoon we are very pleased to have people from the Etobicoke General Hospital. Mr. Story, the administrator and I have common roots in our part of the province and we were sort of reviewing past history. We are delighted to have you here, Mr. Story, along with Mr. Worsley, the associate administrator, Mrs. Margaret Dowsett, the assistant administrator of patient services, and Mr. Robert Young, I believe, the administrative assistant. So, first of all do you have an opening statement, Mr. Story, or any of your people?

**Mr. Story:** Yes, I have prepared one. The draft you can follow is behind the yellow sheet which was given out to you. I'd like to review this and during questions, I'd like to be able to call on either one of my cohorts to answer the questions, if we are able. The content of the initial statement is in this. Behind the blue sheet you'll find there is another document which is a summation of a report to the annual meeting. One item is circled and I would like to draw it to your attention. Okay?

**Mr. Chairman:** Very good.

**Mr. Story:** Etobicoke General Hospital opened its doors to the community to provide health-care services in September 1972. One hundred and thirty of the rated capacity of 508 beds were put into service at that time with the intent of gradually phasing into use the total of 508 beds. In October 1974 the hospital had opened for operation 394 beds but was reduced to 348 by ministry ruling.

In spite of the continuing growth of the population of the borough of Etobicoke and the Malton area of Mississauga, resulting in ever-increasing pressures placed upon its services, the Etobicoke General Hospital has had its approved bed occupancy frozen at 348 beds for the past five years.

Approvals granted for housing construction adjacent to EGH are putting additional pressure on the already strained facilities. We

cannot continue to cope with current volumes of services demanded by the community and contain our operation within existing bed and funding limitations. As a health-care institution, we could only be held responsible for the services provided if we reduced those services according to the resources which are made available to us through the Ministry of Health.

The Ministry of Health has acknowledged a bed disparity existing in Metropolitan Toronto. The borough of Etobicoke has been found short by 130 beds of the accepted ratio of 3.5 beds per 1,000 population. Conversely, the bed surplus to this ratio in downtown Toronto is 12 per 1,300 beds.

[3:45]

While it might seem logical that the bed shortage in Etobicoke could easily be compensated by the bed coverage in Metro, two very essential elements in our health-care system would be violated. We interfere with the doctor-patient relationship and also with the freedom of the citizens of this community to select their own physician.

This type of enforcement referral pattern will not permit this hospital to meet the needs demonstrated by the citizens of the community who have been led by governments of this country and province to believe that a full range of health-care services is universal and therefore reasonably accessible to them.

The economic situation which has resulted in financial constraints on hospitals and other health-care services is understood, and the need for evaluation of productivity is accepted. This hospital recognized this situation in 1974 and the board took positive action at that time to improve its productivity.

For example, the productivity improvement based on hours per units of work which have been effected since 1973 to 1979 are outlined below: overall hospital, 24 per cent; laboratories, 28.4; nursing, 14; and dietary services, 30 per cent. A significant number of maternity cases will have to be referred outside the borough of Etobicoke. We are at present funded for 29 beds and the demand is in excess of 45. Waiting lists for services for both inpatients and outpatients will increase greatly.

To date, Etobicoke General Hospital has attempted to meet its community needs. This has resulted in approximate deficits of \$40,000 in 1977-78 and \$100,000 in 1978-79. We can no longer fund deficits of this kind and, therefore, some action must be taken or we will have to react by reducing services to a point inconsistent with our obligations and responsibilities as a health-care provider in the community.

This situation has been recognized by the Ministry of Health and they have been most supportive and understanding of the dilemma in which we find ourselves. All documentation and supporting data has been supplied to them.

It would appear, however, that as much in sympathy with this situation that they may be, until some definitive action is taken by government to reallocate or redirect the dollars, funds are being wasted to support unused beds in over-bedded communities. Every constrained dollar allocated to health care should be applied where the need exists. We can, and have, demonstrated such a need in our community, a need to which we can respond because we have unused beds lying fallow in our institution. Our required beds are forced to be unused when others are allowed funding for unneeded beds.

The irony of this situation should be evident to all. If the situation is that we must wait for reallocation of beds from the centre core of the city to the needy boroughs, then it is imperative that such reallocation of beds and funds be implemented immediately. Regardless of how quickly or how slowly this situation is resolved, our situation only compounds with each day of delay. We cannot wait for the Ministry of Health and the Hospital Council of Metropolitan Toronto to go through lengthy negotiations on the reallocation of identified surplus beds in the downtown core. We have the beds, we need the funding. Failure to achieve this will result, in the fall, in the drastic reduction to the services we have been providing. We can anticipate a repeat of the situation which outraged our patient population affected when we curtailed service last month, in an effort to reduce our pending deficit.

We have given with this, as I stated, a summary of an annual report, and I referred to one item. It's in the blue section. You'll notice that it has been circled. The inequity built into our present system with regard to trying to get patients to use, or hospitals to provide, outpatient services has been done at the expense of the hospitals. While it has cost the hospitals money, any income gener-

ated through the Ministry of Health has been returned with increases. It is not retained by the hospital. So every hospital that has increased its outpatient volume has actually suffered in the constraint program. That's basically an outline of what is submitted, Mr. Gaunt.

**Mr. Philip:** Mr. Chairman, perhaps I should at least declare a conflict of interest, since I'm a member of the board of directors. But I still have some questions as a member of the Legislature.

**Mr. Chairman:** Yes, I notice that, Mr. Philip.

**Mr. Philip:** Mr. Story, you just dealt with the whole problem of maintaining services. You would have what, 1,000 patients per day in the outpatient services? Over 1,000 now?

**Mr. Story:** There is a total of 1,000 patients a day coming for service to the hospital at this time.

**Mr. Philip:** And this would be greatly increased over the last four or five years. You can project a higher—

**Mr. Story:** In 1974, we were arranging about 450 to 500 per day. We have doubled since 1974.

**Mr. Philip:** Part of the reason for the increase then would be the geographical nature of the area you're servicing, would it not?

**Mr. Story:** In relation to expansion of housing, yes. The population increases in the area, yes. That has a definite bearing in its relationship to the airport.

**Mr. Philip:** And the area you're servicing is not just Etobicoke, but rather the very quickly increasing areas of Mississauga and, on your north, Vaughan county. Is that correct?

**Mr. Story:** Yes, 52 per cent of our patients live in Etobicoke proper, 30 per cent come from the Mississauga-Malton area, about 12 per cent are from Vaughan North and the remainder are from all over Canada and the world.

**Mr. Philip:** I think the hospital board and the physicians employed there pride themselves on the way you've been able to develop day-care services. Would you say that as a result of those day-care services you're actually saving the government a considerable amount of money in patient beds and that kind of thing?

**Mr. Story:** Ed, I'd like Mrs. Dowsett to answer this. She's directly involved in this.

**Mrs. Dowsett:** In endeavouring to expand outpatient services in a hospital pressured



such as we are at the present time, the result is that we increase our outpatient services which should take the pressure off inpatients. Unfortunately, it doesn't. When you increase your outpatient service for that, you make vacancies in the inpatient area which are rapidly filled when you have a growing population and increased pressures on the services you're trying to provide.

By and large outpatient care is a less expensive way of handling health care, if it's possible to do that. We have endeavoured to do that. What has happened of course is increased pressure on inpatients as a result. So now we're doing it both ways with the same number of dollars we had before.

**Mr. Philip:** As you indicated earlier, Mr. Story, pressures on the hospital are such that you have to cut back on community services, which in fact are the day-care sort of outpatient service. I wonder if you can give members of the committee some idea of the distance it would be for patients to go from Etobicoke General to the other nearest hospital to get services. For example, if they go downtown, is it not fair to say that it's an hour or an hour and a quarter on the bus to one of the downtown hospitals?

**Mr. Story:** It is the downtown hospitals that have the beds. The hospitals in the boroughs are quite heavily plugged with patients. The result is that they would have to go downtown.

**Mr. Philip:** But from a very practical point of view, for somebody who has children or job responsibilities, it would be very difficult to spend three hours travelling back and forth for one visit to a downtown hospital, assuming that they're travelling by public transportation.

**Mr. Story:** It's not logical to assume or to expect them to do it.

**Mr. Philip:** I wonder if you can tell members of the committee a little bit more about some of the efficiencies you've been able to obtain as a hospital. Certainly your record shows you were able to bring about economies long before the ministry decided to go on its present cutback and austerity scheme, did you not?

**Mr. Story:** Yes, the board made decisions back in 1974. I'd like to give this to Mr. Worsley, who is very interested in this area. We've all participated in this, since that time, and I think Mr. Worsley could probably give you a better outline on it.

**Mr. Worsley:** Back in 1974 the board hired a firm of consultants. I could give you their names later on if you're interested.

**Mr. J. Johnson:** Woods, Gordon?

**Mr. Worsley:** No, Naus and Newlyn of Canada. They did a study. Actually, they were in the hospital. They were in the hospital from approximately July 1974 to December 1975. The way this firm functions is to have people on every shift seven days a week. The hospital sets the standards of the health care and they do the timing of that. They guaranteed, I think, about \$650,000 a year in savings. They also guaranteed their fee, which was substantially less than that. If the savings didn't exceed the fee, or equal it, they would reduce the fee and they guaranteed continuity into the future for three or four years.

In the contract it said, "We will calculate this based on the salaries in effect in December 1973, taking the lowest salary rate in the hospital." Based on that, the actual savings were \$2,276,000 a year. For a period of three years after these people are finished, they get weekly and monthly reports from us, and they also visit on a regular basis to ensure those savings continue, and they have, to date.

That \$2.2 million in today's dollars is substantially more money. What we also got out of it was a patient classification system which allows us to forecast and actually do our staffing, particularly in the nursing areas, twice a day. It allows you to balance the relationship of casual staff to full-time staff so you can effectively fluctuate the hours you're paying for, to the patients being serviced. We ended up with volume indicators for every department in the hospital.

There's a management summary every week. It's two days after the fact, but it shows the hours of work used, compared to the volumes of services provided. It gives a very current control on what's going on. The monthly financial statements of course provide a historic audit of what's actually happened in dollars. Along with this, we did put in a computer system, which enabled us to have effective and accurate cost centres. We are in a position today, and we have been discussing this with the Ministry of Health, where we have the facility and the ability to do program costing in our hospital. And it is something we are exploring at the moment.

So you have current control of your cost and your staff, which are 75 per cent of your costs. Basically it's current, you know where you're going. It's the only way you can manage.

**Mr. Philip:** I wonder if I can ask a question. I suppose it's a similar question to ones being asked in the justice committee dealing with some educational matters, and

I'm not sure you can answer it empirically. Can you just give me a gut feeling of what it does to a hospital staff when they've gone through all of this, they've shown initial cost savings, and suddenly they find there's no reward; on the contrary, they've got cut-backs affecting their delivery of service after they've already achieved high efficiencies on their own?

[4:00]

**Mr. Story:** I think your problem, again, is one of acceptance of a principle, and selling something to the staff that is tangible. In other words, we're there for one purpose, and that is to prove that every dollar received is being used wisely in the interest of our patient, and to economize as much as possible, so that we can prove we're doing a good job. It's a means of instilling in them to work smarter, not harder.

This was done right from the outset—this is the second time I've gone through this and this is a much larger hospital than before—and when this is combined with our computer systems, the management systems become the important factor. Financial statements are historic documents by the time we receive them. You know what the result is going to be. What we have done is train department heads to manage.

In the total of what we're looking at here, in the next year, there is about \$21 million or \$20 million. To hit within \$40,000 of that in any one year is unbelievable, because there are so many factors working against us. But those people, with the proper initiative, can do it and will do it if top management provides the momentum. You can't expect the people at the lower levels to do it; it has to start at the top. The top must instil in those people the need to improve. There is a lack of incentive for administration in most hospitals to do this, and this has been a very grave area. However, the incentive our people had was to do a better job and we sold it.

**Mr. Philip:** What happens, though, to that incentive when, after they've proved they can achieve economies, the ministry seems to fail to respond to some very essential needs?

**Mr. Story:** Again, it's the attitude of the administration, from the top down, and the board. It can be one that can create difficulty, it can be one that will be supportive to the system. We have the support of the board; we have the support of the administration. They become frustrated, and you continually have to talk with these people. As a group, our management group represents 33 first-line and 48 second-line super-

visors—approximately 80 people. You endeavour to work with these people to do a better job. I do not think lower productivity results from it because I think once the stimulus has started, they are carried with the momentum of the group.

**Mr. Philip:** I wonder if you can give the committee some idea of at least one area that I've been particularly interested in, and that is the need for an isolation unit at the Etobicoke General Hospital. How many people per day do you get from the airport?

**Mr. Story:** Anywhere from 12 to 30 a week.

**Mr. Philip:** I have a letter here dated February 18, 1977, from the Minister of Health (Mr. Timbrell) saying that negotiations were going on. I'd better read his exact words, so that I won't misquote him. There were preliminary discussions and "any decision about adequate isolation of contagious disease is still pending discussions with the federal Department of National Health and Welfare. In the meantime, however, you can assure your constituents that they are not in any kind of danger." Is it not true the ministry approached you, rather than vice versa, concerning the possibility of an isolation centre at Etobicoke General?

**Mr. Story:** I think we would have to go back to 1976 when I got phone calls from the then Ministry of Health to close the hospital over Lassa fever. We closed. The resounding problems that developed from that over the next six months were quite noticeable. At that time we entered into a lot of discussions with the ministry, and we had consultants from Ottawa, regarding the possibility of an isolation unit. We were asked to come up with some ideas and principles that might be worked with. One of your assistant deputies was there.

The problem was that it is an area of federal responsibility. The airport is federal. When problems of the airport become provincial, we have to do something; but unfortunately it's federal when you come to discussion and that is a relationship with Ottawa we can't get involved in. We talked to the carrier associations from the hospital; we speak with the Metro police and we deal directly with what we can. But again isolation is handled, as I understand it now, by agreement with Ottawa. Ottawa handles it. They would probably transport the patients there.

Later, another letter was received asking us to take two portable units in our hospital to use for isolation purposes. It was almost impossible, because there was no way you



could be assured of having adequately trained staff to use the units at any specific time. So it really is not practical to come up with any solutions unless everyone involved determines the principles and the policies we're to work with. Therefore, we have dropped the subject since the beginning of 1978.

**Mr. Philip:** How many patients per day, then? You said you get about 30 from the airport?

**Mr. Story:** Twelve to 30 a week.

**Mr. Philip:** Twelve to 30 a week.

**Mr. Story:** That's right.

**Mr. Philip:** And perhaps two thirds of those would be just employees then, from the airport, but about one third would be people getting off airplanes.

**Mr. Story:** About one third are patients.

**Mr. Philip:** —who arrive at your door along with other outpatients.

**Mr. Story:** I think you have to look at the geographic situation of many of those stairs at the airport. If you've had an in-flight problem with lack of air pressure, those people coming off and going down to immigration have to go down two or three flights of stairs. People fall. People trip on those stairs. They're light-headed. I myself fell on that first flight of stairs when I came back two months ago. This is something that's hard to control. People receive injuries, they're brought to our place, we treat them.

**Mr. Philip:** But it is possible, without too much imagination, that somebody with a very dangerous, contagious, foreign disease could land on your door from the airport without any kind of warning and without any kind of preparation. Not having that isolation unit, there would be a danger not only to your staff but also to the community in that situation, would there not?

**Mr. Story:** We could be forced to close again, if we ran into that.

**Mr. Philip:** How much was the cost of the last closing?

**Mr. Story:** I don't think you could ever put dollars to it. It cost us a lot, but it cost a lot of individual doctors and people, who worked round the clock, a lot more.

**Mr. Philip:** I wonder if you can tell us—and it may be in the appendices to your brief—but what is the length of stay in your hospital, and how does that compare to, say, the provincial average?

**Mr. Story:** I'd like Mrs. Dowsett to answer that. She has them all by heart here.

**Mrs. Dowsett:** Not all by heart. Our average length of stay in the hospital at this point is seven days, which is considerably lower than the provincial average which runs somewhere between eight and nine, if my memory serves me correctly. But the interesting thing is that those statistics themselves don't really mean that much because they have to be related to different institutions and what goes on in different hospitals.

For example, we have a psychiatric unit. Psychiatric units are always much longer stays than a surgical ward, for example. And, even with our 30-bed psychiatric unit, with an average length of stay of 14 for those patients, we are still able to maintain our average length of stay at 7. Again what this means is a much more rapid turnover of patients within the hospital.

We do whatever is possible to generate the beds for the next one to come in. But when there is a rapid turnover of patients, your patients are in hospital during the more acute phase of their treatment, which is also the high-cost time. So a hospital with a short length of stay, such as seven days, is a high-cost hospital in terms of the kind of care they have to provide for the patients that come to them. So all in all, as was said to us by one of the ministry's representatives, a seven-day length of stay in a general hospital such as ours with a psychiatric unit is a symptom of a hospital under extreme pressure from the community for services.

**Mr. Philip:** Mr. Story, just one last question. Was there not a promise to you by Dr. Dyer at one time that when he met with representatives of the board and the administration, he made a promise that he would try to provide additional funds to the Etobicoke General as cutbacks were made elsewhere and savings were made in other areas?

**Mr. Story:** We have been putting pressure on to try to alleviate the bed situation, realizing that the ministry has recognized us to be 130 beds short and realizing that we are in trouble. When you get into areas of medical, surgical and you are down to 5.5, five and six, you've got trouble with your length of stay. At the time, he made a statement that the funds would have to be reallocated from other areas to the hospital before they could consider opening the beds at our hospital; reroute the funds to our hospital.

In subsequent discussions on that, we've had some difficulty coming to grips with this. It wasn't until this spring that we had further meetings on it. At this point, where the money comes from, as I put out in my initial statement, isn't our concern. Our concern right now is to get going and provide



the services needed. That's secondary in our consideration, because we have to have funded services if we are going to provide service in the community.

**Mr. Philip:** Thank you. I could ask a great number of questions but I think that in fairness to the committee I'll say thank you. I would like to mention a personal feeling of disappointment that neither the minister nor his parliamentary assistant is here. I am sure that both of them would find the presentation and perhaps the answers to some of the questions rather interesting.

**Mr. Blundy:** Mr. Chairman, I would just like to ask a couple of questions. Mr. Story, I was very interested in your first page. You talk about the bed situation and the referral pattern, and so forth. Many of us in this committee felt that this bed ratio of 3.5 per 1,000 was a yardstick that could not be used across the province, but that there were some hospitals in the province that ought to have some special consideration.

Just what is the situation at the hospital? Do you have long waiting lists for people for elective admission to the hospital?

**Mr. Story:** Yes.

**Mr. Blundy:** Do you have occasions when patients come to the hospital and have to be accommodated in emergency? Other hospitals I know of, may have six or seven people waiting on cots in an emergency department awaiting a bed in a hospital. Do you have situations like that?

**Mr. Story:** We have a large emergency department, probably one of the largest in Toronto. But one of the difficulties is that we will not accommodate them overnight in emergency. We have beds there we can temporarily put into use for their use. Last year we exceeded 2,895 days over our allotted beds, plus 1,240 new-born days. And patients who come to emergency who require a bed—heart cases, critical cases—we will handle them and we have. We have not referred them to other centres.

**Mr. Blundy:** And the patients referred to the hospital by the doctors are clearly people in that area of service of the hospital, and in your view should be accommodated in that hospital and not have to go down to Wellesley Street Hospital or St. Michael's Hospital, or some place downtown? This is one of your problems?

**Mr. Story:** It's almost like people in Hamilton coming to Oakville for service.

**Mr. Blundy:** Yes.

**Mr. Story:** It takes about as long to get from there to downtown Toronto as it does to get from Oakville into downtown Toronto.

It is difficult to come into the centre core. However, these hospitals are built up out there and they are providing a much-needed service to a large, expanding community. We've only seen a drop in the bucket compared to what's already approved for construction out our way. I understand there are others before the municipal board if they go ahead. It will be quite interesting.  
[4:15]

**Mr. Blundy:** It doesn't seem fair to group your hospital in the whole Metro Toronto area when your area is obviously growing a lot and obviously has a very great need for hospital accommodation.

**Mr. Story:** The boroughs, as a whole, can't wait for someone to play with downtown and determine what's happening. It's not just our borough, it's the boroughs in the periphery of Toronto. They all have a similar problem, and if something is not done, it's going to be a difficult situation.

I indicated in my report that we were funded for 29 beds in 1972 in obstetrics; that's 29 beds per day. We've had as many as 64 patients in that area. We averaged out at 36-plus last year. This year we are looking at an average of 45 per day. To refer those patients into a downtown hospital breaks up the pattern of practice. The patients have been brought along by the doctors. They do not have access to Toronto hospitals so doctors would have to refer them, besides the inconvenience and location. So you have a very grave situation.

There is considerable shortfall, which the ministry has recognized. We've had to re-channel money to pay for obstetrics to date. And we are looking at a sizable sum this year. This is something like \$550,000 we had to rechannel from other sources to pay for last year, and we are looking at another \$300,000 in the coming year. And it's at this point we have to draw the line. In my report I indicated we are at the end of the road.

**Mr. Blundy:** The second point I wanted to talk to you about was the area you just mentioned. In your report you talk about maternity cases that will have to be referred outside the borough of Etobicoke, at present funded for 29 beds and the demand is in excess of 45. This must be most unsettling for people. The wife is having a baby and they have to go all the way downtown away from their families, away from other children who are left at home, and all that. The minister is well aware of these figures and this problem you have laid out.

**Mr. Story:** Mr. Blundy, we have actually not only made it known, we have been pushing it for quite a few years. As a matter of

fact, the year of our Lassa fever we had meetings when the minister was involved and we brought this subject up on a one-to-one and to this point. The problem is, they still have done nothing about it. We have managed to carry what we have done in the interests of our patients. In 1976 we stated we were going to withdraw back to the 29 beds. Realizing the crisis it would have created, we were asked by the then assistant deputy minister to back off, and we did. They have been supportive although I don't think they have been able to generate the finances or the funding which would be necessary.

**Mr. Blundy:** The case you make is an extremely good one and very clearly made, I might say. I have every sympathy for you. The minister is not, certainly, looking at hospitals in any way as a community hospital. He's looking at the whole Metro Toronto area and letting the chips fall where they may. Have you ever thought of taking him to court, like some other people we know?

**Mr. McClellan:** Seems to be all the rage.

**Mr. Blundy:** Yes, it certainly would be worth the try.

**Mr. Story:** I have to go back a few years. I have been in it a lot longer than some of the others. In 30 or 35 years, I'd like to say that I have been in full support of the health-care system. I was in on the meetings between 1952, 1957 and 1959, when they developed. I believe in it, the way it functions, not in the way the funding functions.

**Mr. Blundy:** I don't think your great belief and support is going to continue if the hospital services in Ontario continue as they are. We have been hearing people from all over Ontario and they are telling us the same problems.

**Mr. Ramsay:** Mr. Chairman, before I ask a few questions, this information was just given to me by a representative of the ministry and I pass it along without having any prior knowledge of it. I present it with that understanding. Apparently on the weekend there was an announcement that Toronto General Hospital has been funded for an isolation unit and it's a two-part funding. A central lab will cost \$350,000. Apparently this lab will be on an equal footing with only four others in the entire world, as far as testing diseases relative to isolation is concerned. The isolation unit itself will cost \$284,000 capital, for a total of \$634,000. The funding for the operation of this unit will commence at a level of \$335,000 per year. It appears from what I have just learned that some provision is being made within Metro Toronto for an isolation unit.

**Mr. Philip:** May I ask a supplementary on that new information? I gather the hospital the ministry had been dealing with initially on this wasn't even informed of it. With the new road system now, the airport is approximately four minutes away from the Etobicoke General. I wonder whether the ministry has considered the fact that people will likely go, when they have a problem and they get off an airplane, to the nearest hospital. What is the rationale for putting it downtown when obviously people are going to end up at the Etobicoke General anyway, unless they have terribly severe symptoms initially?

**Mr. McClellan:** Unless the flight attendant makes the diagnosis.

**Mr. Philip:** Unless you are going to give medical degrees to flight attendants so that they can do a diagnosis on the spot.

**Mr. Story:** I'll have to try to obtain that information and maybe present it here tomorrow for your benefit.

**Mr. R. F. Johnston:** Which hospital was it?

**Mr. Story:** Toronto General.

**Mr. McClellan:** Toronto General is right downtown.

**Mr. Jones:** Mr. Chairman, I wonder if Mr. Story, having made some comments about contagious diseases related to the airport, could enlighten us, for example, whether the air facilities perhaps complement for an emergency situation, giving short-term need or care until, say, transport to the Toronto General. Maybe that would be helpful, Mr. Chairman.

**Mr. Story:** I think we are in a better position right now than we were before. I think you have to realize that not all contagious diseases come through the airport.

**Mr. Jones:** Indeed.

**Mr. Story:** And it could well be on a provincial basis that it might be better tied in through laboratory facilities through a teaching hospital. I imagine it would be more easily funded that way.

**Mr. Jones:** I see.

**Mr. Story:** This may be the criterion, although I believe when it was first discussed, the University Teaching Hospitals Association had indicated that they approved it out at our location. I never heard any differently. I am surprised, I never heard anything about this.

**Mr. Ramsay:** This apparently, Mr. Story, was in the newspapers—the Toronto Star and the Globe—on the weekend, although I didn't see it myself.

**Mr. Story:** I didn't see it.



**Mr. Ramsay:** I have just been told it was in the newspapers.

**Mr. Philip:** Is it not the normal procedure for a ministry, dealing with certain bodies, at least to advise—either make the announcement in the House and simultaneously tip off those organizations concerned, or at least consult with them beforehand and say that some announcement will be made in the Legislature, an announcement that obviously affects them, rather than informing them in this off-handed, cavalier way that we have just received the news?

**Mr. Ramsay:** Mr. Philip, I believe it was in the newspapers. I am led to believe that it was on the weekend.

**Mr. Philip:** No, what I am saying is that announcing it in the newspapers is hardly the appropriate way to inform the directors and management of Etobicoke General Hospital.

**Mr. Blundy:** They knew the Etobicoke General Hospital was coming here today, you see, so they wanted to jump in ahead.

**Mr. Jones:** Oh, you can't attach that suspicion, Mr. Chairman. It came up in conversation, so it's a clarification the member is offering.

**Mr. McClellan:** It would fit the pattern to a T.

**Mr. Chairman:** Let's not get into that. Mr. Ramsay?

**Mr. McClellan:** You don't have to be very suspicious.

**Mr. Ramsay:** Mr. Story, I just skimmed through your annual report which covered the period to March 31, 1978, and I don't notice any reference there to problems in funding. Have those problems become acute since March 31, 1978?

**Mr. Story:** No, no they have not. They were carried by the chairman. I indicated though, if you'll notice behind the blue section, that the preparation of the report does indicate part of the current year. We have been very co-operative in trying not to create any problems in this area. We have been able to find ways of trying to control, but it is altered with the present economic level of financing of 4.5 per cent, and union adjustments are coming in at six to seven and eight per cent; something has to give. We cannot fund unapproved services in the future.

**Mr. Ramsay:** This was going to be my next question. Is your problem, and excuse me for not understanding this completely, that you cannot fund your present level of services; or is the problem that you require extra beds

to maintain a level of service and therefore need additional funding?

**Mr. Story:** Both. As I indicated in obstetrics, it's never been funded, the funds have been channelled to carry it. In the case of the shortfall of beds at the moment, unless we receive medical and surgical beds by the fall of this year, there will be quite a public outcry. This is not conjecture, this is a fact, because the pressure has been too great within this past six to 12 months, and it's not letting up.

**Mr. Ramsay:** One thing that's concerned me with all of the hospitals that have appeared before us to date is a suggestion by all of them that there has been a lack of communications with the ministry. You indicate in one paragraph that the situation has been recognized by the Ministry of Health and they've been most supportive and understanding of the dilemma in which we find ourselves. Are you confident that something is going to be worked out? If so, how soon?

**Mr. Story:** I would like to say that I will pray about it; they do recognize the problem, they have for some period of time. Our submissions have been in and the deputy minister understands them, the minister understands them; the problem here is one of cash funding and availability to them of funds. We cannot wait for the reallocation of funds from the centre core; this is going to have to be done now, not in one or two or three years. The crisis is on. Otherwise we start funding them down and then the crisis will develop.

**Mr. Ramsay:** In other words, the ministry has to find some additional funds somewhere or your services will suffer as early as this fall.

**Mr. Story:** That is correct. They haven't said they have funds, they said they are looking at it and they are supportive of what we are doing, what we've asked for.

**Mr. Ramsay:** The point that bothers me is that if they find extra funds it would probably be at the expense of the core hospitals, and then we'll have the core hospitals in here with the same—

**Mr. Story:** That's not my problem, Mr. Ramsay; my problem is to operate a hospital in a highly motivated, growing population. We must provide services. We can't wait. I am a director of the Hospital Council of Metropolitan Toronto. I cannot speak for them, and I cannot speak for the relationship between them and the ministry and their relationship with the other groups, but I can say this, that we cannot wait for reallocation of funds. We need this now. Some-



body has to make a decision and until that decision is made there is nothing we can do.

**Mr. Ramsay:** Have you been given any suggestion of an early decision, Mr. Story?

**Mr. Story:** We have been advised, and this is based on some pressure in the House last March, that they are looking at something with relation to obstetrics and psychiatry only.

**Mr. Ramsay:** And the time frame?

**Mr. Story:** They have not set out the time frame; the discussion was they would try to pick up obstetrics and they would try to pick up psychiatry in the fall, but that still doesn't solve the medical and surgical problem.

**Mr. Ramsay:** All right. One final question, Mr. Story. It was suggested when some of the other hospitals were here that savings that were created by the use of a management consultant were going back to the ministry rather than remaining in the hospital. In the case of your management consulting activities which appear to be extremely productive, have you been able to keep these funds or is that being deducted from your allowable funds from the ministry?

[4:30]

**Mr. Story:** You've got the wrong guy for this one. I have to be honest. We generated that based on December 31, 1973, figures. In 18 months we generated the savings of \$2.2 million and the ministry constraints didn't come in, if you recall, until 1976 when they really lowered them. They have removed more than that in the last three years.

**Mr. Ramsay:** Mr. Story, I hope you're not suggesting that I would ask that question on the basis of not expecting an answer of that nature.

**Mr. Story:** No, they have removed about—

**Mr. Ramsay:** I may be on the Conservative—

**Mr. Story:** I don't know what you are. About \$3.5 million approximately.

**Mr. Ramsay:** I may be representing the Conservative caucus, but I'm trying to be objective in my questions.

**Mr. Jones:** Mr. Chairman, I have a couple of points of clarification. I notice, Mr. Story, in your opening comments you alluded to the fact, and rightly so, that the largest part of your catchment area was Etobicoke, and then you referred to Mississauga. I appreciate your comments about the growth that is taking place in Mississauga, as a member from that area. You referred in further comments about the extra expansion that you're aware of taking place, through the Ontario Municipal

Board, and then you just answered, in reply to Mr. Ramsay, that it was a combination both of growth, I believe your comments were, and to maintain the high level of health care.

My riding is Mississauga North, so as such it catches Malton, and I know a lot of constituents who have spoken very highly of your hospital as they have recounted their visit there. But I wonder, sir, as you're making these projections for Mississauga, whether you're taking into account this growth. Is there anything specific or particular that you could give us, and especially to me as a member for that area, that you would have used as a guideline for the growth you expect from that percentage of your care, which I believe you think is somewhere in the 30 or 32 per cent range? Have you a fix on that? We all know in general terms the growth of Mississauga, but I just wondered if you had some percentages, given 30 per cent of your delivery is from there?

**Mr. Story:** I can't give you any percentage on projection. The growth of the Malton area has been rapid. The growth of the area, when approved, behind Humber College could be a disaster to us. The growth north of us already has closed in, and Vaughan township hasn't exactly sat still. So by and large to try to be God and give you crystal ball figures, I can't. I'm stating facts as they are, knowing that this is going to increase substantially.

**Mr. Jones:** Just on one I might help you. I know the Malton portion of Mississauga is pretty well full as far as areas of development are concerned. I think they've pretty well filled all those corners because of what the airport catches. I am familiar with the other areas over in my colleague's section, which of course I guess are going to have growth. I know Malton is considered by the town fathers, as it were, to be pretty well full as far as areas of development are concerned, certainly from a residential area.

You were mentioning in several of your comments that 1974-75 was the year of your contract for study, and as I read the results in the report here I compliment you on coming within \$40,000 of a \$23.5 million budget. You mentioned how you have senior management handing down from the top this spirit of efficiency, but do you have anything by way of budget control committee, or similar name operating as well, or in concert with this onward going program?

**Mr. Story:** We have a total involvement of all management and department heads.

**Mr. Jones:** So they serve as a committee on this.

**Mr. Story:** They function as a group. We have an administrative management committee, which consists of nine to 10 people of whom six are permanent members and four rotate through other department heads. There are 33 department heads as such. From our point of view this deals with the directives, the policies and implementation, reviewed daily and weekly; our status-to-work-volume indicators, and every manhour and every department in the hospital.

**Mr. Jones:** Can I ask one other further thing? It was referred to by I believe Mr. Philip that there had been promises or certainly hopeful indications from Dr. Dyer that when funds would become available, there would be consideration given, and your comments have touched on your relationship with the ministry. In answer to the most recent member who put questions, you did refer to a lot of supportive dialogue. Would you dare to, or would you share with us some characterization of your relationship with the ministry overall?

Interjection.

**Mr. Story:** The man took the words out of my mouth.

**Mr. Jones:** You've mentioned the monetary side of it.

**Mr. Story:** Basically, boards in hospitals are flying by the seat of their pants. To try to project a budget and live within it, you have to be God. There are so many underlying factors that are unpredictable. The ministry has been receptive to prolonged discussions but it really has not generated the funds that are necessary. We've tried to make the best use of funds. However, I don't know what the answer is. But I know they must have a problem, otherwise they'd probably be following through.

**Mr. Jones:** They are saying the communication has been good.

**Mr. Story:** It has been good with our hospital, but remember—

**Mr. Jones:** —and there is an understanding that the dollars have not.

**Mr. Story:** Well, as soon as you get to the money, there's dead silence.

**Mr. Jones:** Could I take you back for just a moment? This will be my last question, Mr. Chairman. Back to a discussion that must concern all of us. You were talking about the 12 to 30 people for I think you said weekly admission, coming from the airport, for one reason or another. I think he referred to people becoming dizzy after

flight, falling down escalators, that type of thing.

**Mr. Story:** Stairs, not escalators. They don't have escalators in the immigration area in Terminal Two.

**Mr. Jones:** So it's in the immigration area that a lot of this is happening.

**Mr. Story:** No, when you come down to the lower level in Terminal Two, you've got about three flights of stairs. It's a disaster coming off a plane and hitting those if you've had a problem.

**Mr. Jones:** Following from that, though, we get into something that has to worry us all—the contagious disease matter that we heard about. You mentioned the federal involvement. Do I understand correctly? Is there a unit that has some federal involvement within your hospital?

**Mr. Story:** No, what I was saying is that in 1976 the responsibility for isolation of contagious diseases was a federal responsibility. People entering the country through immigration and otherwise. We were involved with Lassa fever. We had to make certain closures. We were involved at that time. To be quite honest, to move ahead into something at our hospital, into an isolation area, would be a real problem from our point of view, because we don't have the proper lab facilities. Putting the two together at some location is essential. If this has gone ahead, I'd be very pleased to see the full documentation on it, because this is something that is needed here in Ontario. I'm very pleased if it has come out now, and I'm pleased also that we're not getting it.

**Mr. Jones:** I see, because I took from the original—

**Mr. Story:** We were asked to take it originally, and it was fostered, and we could see that there would be a need. Remember, you've got one main entry at Malton airport, a metropolitan airport, but you can get patients from all over the province with diseases or other problems that will have to be looked after. It's easier to take a patient to a facility than it is to try to put something on the doorstep of the airport.

**Mr. Jones:** So, on first blush, while you didn't have a chance to see it earlier, you're not necessarily in disagreement with it?

**Mr. Story:** No. It is one of those items that did come up that we became very close with the ministry over at that time because we were all thrown into quite a conundrum. We've had a very strong ongoing relationship with them in discussions, problems and what not, but really nothing has generated. We've



tried to do our homework. We've tried to improve and we hope we've established norms and factors that can be used elsewhere. Our work measurement programs were used as a base to foster other hospitals getting into the area within the past year on these programs that were done across Ontario. This is good, but we're not in a position to receive the funds to alter beds, which is the crisis at the moment, and to maintain services that we have.

**Mr. Jones:** Maybe one hopeful note will come out of it. Unlike Mr. Philip, who was alluding to the fact that the minister himself wasn't here, nor was his parliamentary assistant, at least we know that he is attentive and following the proceedings here by the fact that he did have clarification on this one point ready at hand. I appreciate your comments. I am familiar with the Etobicoke hospital and the catchment area that comes over into my riding. Thank you for your attendance and for your comments.

**Mr. Story:** I think, Mr. Jones, you're Mrs. Dowsett's member.

**Mr. Jones:** Ah, indeed, Mrs. Dowsett.

**Mr. Chairman:** Mr. Johnston, Mr. Sweeney and Mr. Kennedy.

**Mr. R. F. Johnston:** Does that mean I should be brief?

**Mr. Chairman:** No. I just wanted to alert the other two members as to the order.

**Mr. R. F. Johnston:** My riding is in Scarborough and we have a very similar population increase to your own. We have the same kinds of constraints being placed upon us out there that you're finding based on this Metro plan, if you will, for working out hospital bed ratios. I think your presentation is very clear, very succinct and, I think, makes some very obvious conclusions that I'm surprised that the ministry hasn't responded to already.

I want to talk a little bit about growth if I can. You said you weren't particularly aware of the population increases for the area of Mississauga, the Vaughan county area, but there is a development that is just developing behind the hospital. What size is it going to be, do you know?

**Mr. Story:** Are you referring to the one on the north side of Humber College Boulevard?

**Mr. R. F. Johnston:** Is that known as the Woodbine development?

**Mr. Story:** Oh, that's bigger again. That's on the other side, back of Humber College.

**Mr. R. F. Johnston:** Tell us about both of them then.

**Mr. Story:** I can't remember the number of high-level, low-density housing units. It's in district nine plan. But it looks as if we're getting into another area like the end of Kipling, with apartment buildings and low-density housing. From what I can eyeball in, it looked like an area of about another 5,000 to 25,000 people out there. The one adjacent to us, which is right above us, will probably bring in about four to five. But remember the end of Kipling. The Cadillac Fairview development there is quite a sizeable development with those highrises and there is a large population shift there.

**Mr. R. F. Johnston:** Right. So you're saying there are two areas whose total would be something like up to 25,000, or one of those might be?

**Mr. Story:** The figure I have heard is in the area of 25,000 for the area immediately north of us in the Woodbine Downs area.

**Mr. R. F. Johnston:** And the other one is on top of that?

**Mr. Story:** That's been going now for the last few years and it's been developing.

**Mr. Philip:** May I ask a supplementary? Is it not also true that the Kipling North development, particularly the highrise limited dividend buildings which are about 25 or 26 storeys high and have just thousands of people in them, tend to attract the kind of tenants that frequently have a good many children but are also transient to an area? They're people that often have not yet established roots in the community and, therefore, are more likely to put strains on your outpatient services rather than going directly to a family physician in the neighbourhood because they simply do not have family physicians in the neighbourhood that they've developed contact with.

[4:45]

**Mr. Story:** That is very true. As a matter of fact, there are a lot of people who have come into that area who have had no relationship with the doctors. They end up in the hospital and they are looked after. But remember, we classify the patients who come in and we try to keep a record of where they come from. While we run 30 per cent inpatients admitted to hospital in Mississauga, we run something like 40-some per cent inpatients for emergency, and it doesn't relate between inpatient and outpatient. We do have a large number of outpatients, people who come there, and we are running around the 50-50 mark in total.

**Mr. Philip:** Isn't it also true that many of these people do not speak English?

**Mr. Story:** Very much.



**Mr. Philip:** Therefore, that creates staffing problems for you. You have to have people, particularly in times of emergency, who can deal with somebody in Punjabi or other languages that perhaps another type of hospital might not encounter.

**Mr. Story:** There is no question the area is quite a mixture of languages. One of the major problems is a large Italian population north of us, at Woodbridge and in the Bramalea area. We also have other language groups. If you go into emergency at any time you are liable to see every nationality there.

**Mr. R. F. Johnston:** Just to continue from this, one of the figures that is not in your presentation today, but is back in your annual report, from your chief of medical staff, if I recall, is that you had an 88 per cent occupancy rate in your last year.

**Mr. Story:** That's a year old.

**Mr. R. F. Johnston:** Do you know what it's at at the moment?

**Mr. Story:** For the 1978-79 year, we are over 90 per cent, but we are running about 140 per cent on obstetrics.

**Mr. R. F. Johnston:** That's what I was going to ask.

**Mr. Story:** We are running about 100 per cent plus in psychiatry. We are picking off into the 90s in medical and surgical. We have one of the largest psychiatric units in Toronto and we are running at 97 per cent occupancy, which is high. I am sorry, the largest in paediatrics, where we are running around 80 per cent.

**Mr. R. F. Johnston:** Just to correct the record, it isn't the largest psychiatric section; it's a small one actually, isn't it?

**Mr. Story:** No, it is not; it is paediatrics. I must apologize for saying "psychiatric."

**Mr. R. F. Johnston:** It's an interesting Freudian slip. Some days I feel the same way.

**Mr. Story:** Definitely it was paediatrics I was referring to. Our problem in paediatrics is that we have a young community all around us. There are a lot of children. Our births this year will probably be around 2,500, which is one of the highest in Toronto as well.

**Mr. R. F. Johnston:** The reason I wanted to emphasize that and to get it into the record is that we hear a lot of talk about 85 per cent being a maximum kind of figure. In a lot of cases, given the spread of services that are delivered, we have to consider a lower percentage than that for a

safe occupancy rate. Is there concern in your mind as far as a major disaster or major catastrophe happening in your area as far as your ability to cope on an emergency basis is concerned?

**Mr. Story:** We have been lucky to this point to have extra space that we can use if we have to, but it's not funded. At the time of the airport disaster last year, when we had 19 seriously ill back patients, we were fortunate in that we had just cut back one quad, which is 18 beds, the day before to do service work in it; so we put it back into use. We were able to fit it in. It was a well-timed accident.

**Mr. R. F. Johnston:** That's handy when they are. I know that at Scarborough Centenary Hospital there are actually floors that are vacant and unfunded at this point.

**Mr. Story:** We don't do that.

**Mr. R. F. Johnston:** You have about 100 beds which are not funded at this point. What's their status? Are they all over the building?

**Mr. Story:** No. We have 10 psychiatric beds that are held and we have 20 obstetrical beds held now. We have one floor of 72 beds, medical and surgical, that are held, and some 40 paediatric beds.

**Mr. R. F. Johnston:** What does "held" mean exactly? Does "held" mean vacant?

**Mr. Story:** They are vacant. We've had to move into them under pressure periodically and that's how we get into our present—

**Mr. R. F. Johnston:** Is that how you get into deficit as well, by using those beds for which you get no funding?

**Mr. Story:** We've been fortunate that we haven't gone in too far.

**Mr. R. F. Johnston:** When you talk about having 144 per cent occupancy in obstetrics on occasion, each time that happens are you eating into beds that you're not receiving funding for?

**Mr. Story:** That is correct. We're only receiving funding for 29 while we have been running an average of 36 last year. Now we're looking at 45 this year.

**Mr. R. F. Johnston:** Have you presented a tendency as in obstetrics for you to go over the occupancy rate, that, rather than somebody go to a different hospital, mainly because if somebody deals through a very specific doctor and has gone through the whole labour process with that doctor? Is that the case?

**Mr. Story:** Yes.

**Mr. R. F. Johnston:** So this is going to be an ongoing and increasing problem for you.

**Mr. Story:** Yes.

**Mr. R. F. Johnston:** I have a question about the psychiatric side of things as well. We've had major discussions here about the Lakeshore Psychiatric Hospital closing. We had someone from the hospital here, as a matter of fact, to do with the mayor's task force.

**Mr. Story:** Yes.

**Mr. R. F. Johnston:** Already I'm getting a reaction without getting into it.

**Mr. Story:** I was just curious. Did Etobicoke get here? You answered my question for me before I got it in.

**Mr. R. F. Johnston:** Yes. It did. I find it interesting that you already had discussions about the 10-bed expansion. I presume that's directly attributable to the thing.

**Mr. Story:** No.

**Mr. R. F. Johnston:** This is another thing?

**Mr. Story:** Regardless of that, this is what we've been trying to get.

**Mr. R. F. Johnston:** So you've got to expand by 10 beds anyway.

**Mr. Story:** That's right.

**Mr. R. F. Johnston:** Have you been approached by people like the mayor's task force and others as to your needs, if Lakeshore Psychiatric Hospital closes, in terms of total beds?

**Mr. Story:** I don't know how to put this. We got involved more or less because people couldn't tie things together. I think you'll find we wrote the report.

**Mr. R. F. Johnston:** Of the mayor's task force group?

**Mr. Story:** We assisted them to put it all together. Mr. Young here and ourselves literally wrote it. Because there are so many groups involved in trying to make it fit and make it work, we helped them to do this.

**Mr. R. F. Johnston:** We've heard some very impressive testimony about the organizing of the community involvement in that planning process.

**Mr. Story:** It was good.

**Mr. R. F. Johnston:** But they had to come to you to get the report together?

**Mr. Story:** No, I wouldn't say they had to come to us. Dr. Rzadki worked on the mayor's task force. His expertise is in psychiatry and not in the area of putting things together in reports. When you have about 20 different groups all vying to get something

in, somebody has to make decisions and someone's got to put it together. In the interest of expediting in a short time frame, we agreed to assist them. We spent long hours on getting it, and we were very happy to do it because it does affect us.

**Mr. R. F. Johnston:** I would like to ask you how you feel it affects you and to hear some of the thoughts you have as to what might be expected of you. It struck me about that presentation, and others that that is exactly what was happening. There was an indication that more money was going to be available to community groups and groups started to come together to get a piece of the pie. All were trying to get part of it, whether they were existing groups which had some funding or new groups which thought that they had a new slot to fill in.

We here expressed a little concern that that was the way planning for psychiatric services in the community went on. We felt it would be better not to close, or to plan first and then to close, if necessary, but not to throw up some money and get people scrambling for it. That's just my own aside. What sort of ramifications do you see Lakeshore's closing having for your psychiatric acute care?

**Mr. Story:** It's not going to affect patients coming to our hospital for treatment. It will affect the placement of those patients into another centre to get more ongoing care and treatment, and be brought back into the working force in society. I think we understand that Queen Street will be in a position to handle that and the volume of patients we have. We've not come to grips with it because we haven't been faced yet with referring patients there. Lakeshore has been very supportive and very co-operative in the past.

I agree with you, that there have been statements regarding money floating around, but I don't think that was a basis we looked at. Some of the groups that thought there was money didn't get put in the report. The ones that were an ongoing need were the ones that were developed. You'll notice sections three and four suggested that the ones that were in detail were the ones that we're supporting.

**Mr. R. F. Johnston:** Can you say what effect the inpatient flow will have? It was very hard to tell, because we had a number of suggestions of what might be happening out there, none of which at that time were approved. I don't know if they have been since. I don't think we've heard yet. Have we, Mr. Chairman—



**Mr. Chairman:** No.

**Mr. R. F. Johnston:**—about any of the community projects? We heard things such as that the detoxification side of the alcoholics unit at Lakeshore might be transferred to you, and a number of other possibilities of general hospitals taking on more of the load, is the way it was put to us. I wonder if you can tell us a bit about your end of that.

**Mr. Storey:** I think we're mixing apples and oranges, here. In 1973 and 1974 a gentleman representing the Ministry of Health came to the board of the hospital to place a detoxification unit in the northwest end of Toronto. Our board agreed with the principle. We moved in with the committee that was established through the Addiction Research Foundation involving the police and all. We prepared documentation for presentation after discussions in 1975.

We had the approval in principle; the move was cut off because of lack of funding.

A year ago, November 16, the minister announced to the Social Planning Council of Etobicoke that it would be funded this year. Last July 17 I received a letter advising me to get all the documentation ready; it was all go. We activated the committee, we prepared our presentation, it was put in November 30. We heard nothing about that until about three weeks ago. At that time this involved a detoxification unit at the north end. In that letter was approval for the operating costs of a detoxification centre—no capital, site reserved.

In dealing with this and the doctor who sent it to us, we found out that they did not want it at the north end. That was why they weren't happy with the site. Second, we found out since working with the Lakeshore situation that they had developed something on their own, whether it was known or unknown, last November, relating to alcohol, which was being handled there. This may have been why the need, as I understand their claim, is in the south, not north. We've approached the mayor and said, "The funding was here. As to the principle of it being up where we are in our catchment area, we're happy to provide it, if a site can be found, which is difficult because it has to be approved."

If, failing that, if their contention is that it must be in the south, then I would suggest that it be handled by the mayor and the ministry to decide what's going to happen, because we can't get involved. The distance is 10 miles away—you can't operate something that far off. So that's basically what has happened.

**Mr. Chairman:** Mr. Philip?

**Mr. Philip:** I don't know where you get your referrals for the detox centre. Has the establishment of the Metro West detention centre in the immediate vicinity in any way affected the number of referrals?

**Mr. Storey:** It hasn't, not to a detox. But it has affected a lot of the work we do at the hospital. We have a continuing stream of vehicles coming in with inmates for treatment of one form or another from happenings at the jail. We've had quite an increase in volume, and also patients in surgery. This has been ongoing since they arrived.

**Mr. Philip:** The way in which your staff handled somebody from Metro West detention centre would involve increased staff time, would it, as compared to handling—

**Mr. Storey:** We used to have to give it top priority and expedite them through, and if they are patients in the hospital, they have to be manned by police. This also requires a degree of isolation, some separation.

**Mr. Philip:** So in other words, it complicates and takes additional staff time to—

**Mr. Storey:** We don't get paid for a private room for an inmate from the detention centre.

**Mr. Worsley:** We lose that revenue.

**Mr. R. F. Johnston:** One last question, and that's to do with some of these bed increases that the ministry has been discussing with you. What's the dollar figure on the obstetrics increase, the psychiatric bed increase, that you see as far as your budget goes?

[5:00]

**Mr. Storey:** If you're talking about the catchup on obstetrics or psychiatry, say for 12 months, and say 36 medical and surgical beds, you're talking about an annualization of about \$2.5 million. If you're looking at a timed situation, probably obstetrics from April 1, psychiatry from September 1, maybe 18 beds in October, 18 in January, you're talking about in this fiscal year \$1,575,000. This is over and above the existing situation. We feel that with this we can meet our obligations for the outpatient increases, and be able to come through with the very tight situation. But unless something like this does occur, we won't be meeting the needs of the patients that we serve.

**Mr. R. F. Johnston:** What's that in a percentage increase? What does that do to your overall—10 per cent?

**Mr. Storey:** We're over \$20 million. So by the time we get to it, you'll probably find it



might be around eight to ten per cent. That's on an annualized basis.

**Mr. R. F. Johnston:** This has formed part of the discussion of your close and intimate relationship with the ministry, as I understand it, and your ability to talk well together, except getting down to whether or not they would go along with the money side of this. Or have you talked much in terms of these dollars with them?

**Mr. Story:** Oh, we sure have. I think the problem is whether they have the funds to give, to approve. They may approve in principle, they agree. Where do the funds come from? We're just out in the periphery trying to generate something, and unless there's a concerted effort to generate the funds to get this moving, there's going to be problems.

It's whole boroughs; it's not just ourselves. Your borough, particularly, has a problem just about equal. It's not as bad as ours; I think your shortfall was less than that.

**Mr. R. F. Johnston:** Yes, that's right.

**Mr. Story:** The problem is there is a lot of money required to handle what we have, and I think Scarborough is the other one.

**Mr. R. F. Johnston:** I guess what I was trying to lead to, then, is that the ministry is supportive, they see your need, they see the rationality of what you're saying, and they're blaming it on Treasury, primarily?

**Mr. Story:** No, I don't say they are blaming it on anyone.

**Mr. R. F. Johnston:** Or are they saying that you should be able to handle it?

**Mr. Story:** No, they are saying there are no funds available. Tough. We can't get funds. They've gone over this and agreed in principle with everything we want, but when it comes down to providing the money, we don't know who provides it.

**Mr. R. F. Johnston:** So they're supporting the Metro rationale, then. The idea that the beds in the centre—

**Mr. Story:** They have been until now, which we cannot wait for.

**Mr. R. F. Johnston:** Have you seen any indication that they may be moving away from that rationale, where city of Toronto beds are used in determining whether or not you should get an increase?

**Mr. Story:** I have had no indication from them that they're going to be able to do it. They are hanging their hats again on the situation of reallocation of funding and what I said in my report is that we can't wait.

**Mr. Chairman:** Mr. Sweeney?

**Mr. Sweeney:** Thank you, Mr. Chairman. Mr. Story, the bottom line seems to be, after having listened this far, that the restrictions are being placed on you and you're saying you no longer can afford to handle the deficits; that if someone comes to your door and requires a service for which you haven't a funded bed, barring emergencies, of course, you'd simply have to tell them, "Go someplace else." Is this really what it boils down to at the bottom of the page?

**Mr. Story:** Yes.

**Mr. Sweeney:** For example, the term you're using here is "demand." For your maternity cases you've got 29 beds funded, but how about the actual demand—you use the word "demand" as a synonym for "need"—basic requirements, uncomplicated need. So therefore once you've filled 29 beds the next mother-in-waiting has to go someplace else. Is this really what it means?

**Mr. Story:** Yes.

**Mr. Sweeney:** That's it, eh? Barring again absolute emergencies. On your first page, there are three or four different references to bed numbers. You've got 508, 394, 348, et cetera. In the last paragraph, you make the observation, "We have the beds; we need the funding." From the last line of questioning, I gather that scattered throughout the hospital there are 100 beds that could be put into use; you just don't get the necessary dollars to pay for them if you put them into use.

**Mr. Story:** There are 508 beds in total. There are 348 beds approved right now. There are 160 beds in the house available for use, if and when we have funding and there is a requirement.

**Mr. Sweeney:** They're actually sitting in place someplace.

**Mr. Story:** Yes.

**Mr. Sweeney:** Just having them there must cost you something. Even if you don't use them, there's got to be a cost factor.

**Mr. Story:** Well, put it this way. Our hospital, being a 508-bed plant with outpatient services a 500-to-600-bed hospital providing outpatient services—you have a situation where 348 beds are carrying that. Therefore your plant is large, your fixed costs are high, and you're absorbing a large portion of the outpatient costs; because of the limited method of funding, outpatients are restricted. If I go \$200,000 over on outpatient income, I don't keep it. I lose it. Yet I pay the costs. This is part of the inequity.

**Mr. Sweeney:** Let me follow another line of reasoning and see if I'm right. That ex-

cessive plant being carried, to use your terms, by 348 beds—just for the sake of discussion, let me use a couple of figures—your per-patient-day cost just for the sake of discussion might be \$150. Where is it when in fact you are operating closer to capacity? Would it not be a fact that your per-patient-day cost would be less?

**Mr. Story:** That is correct.

**Mr. Sweeney:** Could you give me a ballpark figure of a percentage less? Or even a dollar figure, if you've got it roughly calculated? In other words, what would the actual per bed or per-patient-day savings be, if you were operating at closer to capacity?

**Mr. Story:** I have to explain something before I get into that.

**Mr. Sweeney:** Does my line of reasoning make any sense, or am I off in the field somewhere?

**Mr. Story:** Yes. But to answer your question I have to qualify it. If your gross cost runs out to \$176 a day and your net cost is \$143, the income factor that's reduced in between is a factor that is based on services provided through OHIP and through the Ministry of Health. That reduces the total to \$143. That is caused by the outpatient income, which is a book figure in and out.

In effect, if you are running \$176 gross and \$143 net, your inpatients are actually absorbing a lot of the actual cost of the outpatient services, because the income factor does not relate to cost. It relates to an arbitrary value that's been established for book purposes. In our case, if we were running \$176, we're totally open. You would drop that down considerably. You might come down 15-20 per cent.

Remember that even on that \$176, about one third of that cost is outpatient services which we haven't got a handle on, nor do they require it. We work on a net/gross, and the income is the difference. That's really clouding the issue but I think the fact is that the two things have to be looked at.

**Mr. Chairman:** Is that arbitrary figure, Mr. Story, set out by the ministry, or do you set that out?

**Mr. Story:** No, that's set out on the methods of billing emergency outpatients, OHIP. That is all that goes through it. You're allowed so much based on the previous year. If you go over, it's taken off the ministry portion. You do not get compensated from a cost factor.

**Mr. Sweeney:** You refer to the fact that you've had a deficit of \$40,000 and are now

looking at one for this year, 1978-79, which is now complete fiscally, I guess—or is it?—

**Mr. Story:** Yes.

**Mr. Sweeney:** —a deficit of \$100,000. Who pays that deficit? Where does the money come from?

**Mr. Story:** The hospital has to accumulate it in future years.

**Mr. Sweeney:** It's carried on your books as—

**Mr. Story:** Capital funds. It's all you can do.

**Mr. Worsley:** You've spent money you'd otherwise spend for medical equipment.

**Mr. Sweeney:** So there is no restriction on you of switching funds from capital to operational, such as there is in school boards, for example.

**Mr. Story:** Yes, there is, oh yes.

**Mr. Sweeney:** Well, I missed it. I gathered you said that instead of buying equipment, you're paying your operation costs.

**Mr. Worsley:** You're not allowed to use theoretically capital funds for operating costs of a hospital.

**Mr. Sweeney:** Excuse me. Do you appreciate the fact that the members of the committee really don't understand an awful lot of how you people operate? That's the ignorance of our questions.

**Mr. Story:** I'd like to comment. An awful lot of the ministry doesn't either.

**Mr. Worsley:** Let me put it this way. The Ministry of Health provides operating revenue for a hospital to pay operating costs. On top of that, there is cash flowing to hospitals and actually it's a capital grant—it's depreciation. There are some questions as to how that's financed too. Theoretically, the hospital has to go out and raise the money to buy equipment first, from donations. Then, over the estimated useful life of the pieces of equipment, the Ministry of Health will pay the original cost back to the hospital. Those are the funds we're dipping into, to pay for deficits. Ten years down the road you're not going to have the money to replace that X-ray machine, or whatever it is, because it's been consumed in operating deficits.

**Mr. Blundy:** Could I ask just one question right here, Mr. Chairman? When I was on the hospital commission, we also got a certain amount of dollars out of private room accommodation. Does that still accumulate for hospitals?

**Mr. Worsley:** That's still accumulating, yes. This is the other source.



**Mr. Blundy:** That was really the only source we had of putting in any major money into any project that we undertook.

**Mr. Worsley:** You've got to remember, though, when a hospital is constructed—take our institution; it was opened in 1972. I can't remember the exact figures, but I think you're into \$15 million or \$20 million or something. There was a loan provided by the province and the federal government, and the community picked up one third. We only retain three-eighths of our preferred income. The balance of that preferred income goes back to the Ministry of Health, either in loan repayments or as their share.

Therefore what you're left with isn't very much. First, your share of the preferred income goes, and then secondly, if we allowed these deficits to continue, the only other source of funds you've got is either your depreciation funds received by the Ministry of Health or donations from the public. I don't really think it's fair for the public to donate funds to a hospital for equipment and have it used up for—well, we can't use it up for deficits, that's all there is to it.

**Mr. Sweeney:** You made reference a couple of times in your brief to 1,200 to 1,300 excess beds in the downtown hospitals. We understood from the minister's opening statements that the whole purpose of bed cuts here and there, this rationalization, should eliminate that kind of surplus. How does that happen? In other words, the beds should be where they're needed and you've obviously demonstrated the need is there, not just the want. How are you short yet they have so many?

**Mr. Story:** I agree. That's what we've been pushing.

**Mr. Sweeney:** I'm not arguing that it is or is not the case, but how does it come about to be that way? How do you understand that to happen?

[5:15]

**Mr. Story:** I think Ontario is built up in the outlying centres. I'm not referring to Oakville or Hamilton. I'm referring to Ottawa. They have special units in outlying centres. They're doing a lot more. Your children's hospital in Ottawa would have a direct effect in London. It would have a direct effect on Sick Children's in Toronto. Their expertise is in many centres. It's not just contained within Toronto. Your population shift outside to the boroughs has created a problem. I don't think there's any one answer to it. This came about at a time when there wasn't that much expertise, other than in large hospitals.

Places like Owen Sound, many small centres, have got some very sophisticated hospitals.

**Mr. Sweeney:** Mr. Story, let me come at it this way. I could understand if this was a residue from 15 or 20 years ago. But within three or four blocks of where we're sitting right now I see one hospital on University Avenue that was completely replaced. I see another hospital right across the street from it that has a fairly massive new addition being put on it right at this moment. I understand there's another hospital a bit farther down that's going to be completely replaced, either on site or on another site.

**Mr. Jones:** You're not against that or anything? You're not criticizing?

**Mr. Sweeney:** Oh, no. All I'm saying is if we had this desperate shortage in the boroughs and this so-called excess in the core, what the blazes are we doing more for? It doesn't make sense. It comes back to this whole question of who's planning for what and on what basis.

**Mr. Jones:** Maybe they are different types of beds.

**Mr. Sweeney:** A Mount Sinai bed is no different from a bed anywhere else. A Toronto General bed is no different from a bed anywhere else. A St. Michael's bed is no different from a bed anywhere else. I'm not talking about specialty hospitals. That's right now. That's not 20 years ago.

**Mr. Story:** I'm not in a position to discuss that because I don't know the facts, but some of you mentioned they need updating of facilities that are in bad shape. This is being proceeded with. I'm not familiar with whether there will be a bed reduction or whether the number will stay the same. I do know we can't wait until they decide what they're going to do out in the boroughs. We've got a problem.

I agree with you. I don't know what they're doing directly in that area, but the ministry's own figures of the overbedding was in that range—1,200 to 1,300. The indication we have was that it should be reallocated and used in the areas where it was needed. We agree wholeheartedly, but we're not in a position to wait until someone makes up his mind on how they're going to do it.

**Mr. Sweeney:** Mr. Story, the answer you're getting—that there isn't enough money to do what needs to be done in Etobicoke or in Scarborough or someplace else—is surely not the full answer. Part of the answer has got to be that someone's making other kinds of decisions for other reasons that use up that money—decisions which don't appear on the surface to make as much sense. I don't



want to put words in your mouth. Leave it at that.

**Mr. Story:** No—

**Mr. Sweeney:** Leave it with a frustrated member of this committee who doesn't know what else to say. Just one last question—

**Mr. McClellan:** You don't know where to cut the funds. The assumption that the money is all there in the system and that it's to be moved around is—

**Mr. Sweeney:** All I'm saying is that's not the only answer. That's not the only answer.

You make a reference in the very last sentence of your report that we don't want to repeat a situation which outraged our patient population last March. What in fact happened last March?

**Mr. Story:** We were endeavouring to meet the requirements of patients and from September on until the end of the year we ran up in excess of 3,000 patient days over and above our projection. We were heading into a massive increase in that. We got our factors off. We had to delay vacations, because we couldn't let people off, and on March 8 we had to make a very firm decision that we would have to cut bookings and get people out on vacation. We had a large sum of money to pay out in three weeks within that year or be faced with the problem of having to get casual help in, where possible, to cover, which could have doubled the cost.

We managed to get those people in, in the succeeding two weeks, but we delayed our bookings and we managed to come through and we absorbed. We cancelled bookings for two or three days, then we got caught up with it later. We actually shut down quads in the hospital, with 18 beds each, and we got out on vacation and we paid off our vacation for last year by the end of March, otherwise we would have been carrying liability over into this year of something like \$89,000. That was why we did it.

**Mr. Sweeney:** In a way then, Mr. Story, I'm coming full circle in my questions, because you might remember the first one was that if in fact you can't acquire any more deficit, you're simply going to have to tell people you can't take them in. That literally, probably for partially a different set of reasons, is what you did last March.

**Mr. Story:** That's right.

**Mr. Sweeney:** And yet you're ending up your report by saying we really can't do that.

**Mr. Story:** We don't want to do it.

**Mr. Sweeney:** I'm only highlighting the bind and the dilemma, and literally the paradox you find yourself in.

**Mr. Story:** If we're going to provide the services to the people, we don't want to do this. We feel it's horrendous. But if you have a system or a staff built up, professional staff, it costs money to replace. You pay on vacation. You replace those people. You've got to pay a second time.

When you come down and you delay and delay and delay, you come down to the wire, you have to make decisions. All right. This is one that was made. It was unpopular and I believe it was brought up. It was quite a crisis at that time, but we have had closures of quads in summer when cut back, and we've had no difficulty with it. We used this period to reserve the areas and get them back in service. So we don't have to shut down during our peak periods.

**Mr. Sweeney:** But the fact remains that last March you had an experience which you really don't anticipate, or really wouldn't like to repeat, and yet in fact that's literally where you're being forced to go.

**Mr. Story:** What I'm saying is that we won't repeat it. We will not take the patients starting the fall.

**Mr. Sweeney:** Period.

**Mr. Story:** We will not take the volume of patients and emergencies will come first. We'll book in from there, and if we cancel, we cancel. You delay your bookings into the future and pray that you have beds to handle.

**Mr. Kennedy:** When you say that you won't be able to take a patient, what then is the alternative—one of these in the Metro area?

**Mr. Story:** When you say "not take a patient"—

**Mr. Kennedy:** If you're unable, you haven't sufficient capacity to take the patient, and you say, "Sorry, you'll have to go elsewhere."

**Mr. Story:** Yes.

**Mr. Kennedy:** What's your experience? What happens then?

**Mr. Story:** Well, it depends on what you're looking at. Emergency, we try and handle first. If it's a booked elective case, they may have to be referred to another surgeon, another specialist. This affects the pattern of practice; or delay it into the future.

**Mr. Kennedy:** I'm quite intrigued, or it's re-emphasized, this surplus of 1,200 to 1,300 beds and really, following along what Mr.

Sweeney was saying, some time ago, when I was a kid, there was no Etobicoke General, no Queensway, no Mississauga. We had St. Joseph's and we had the General, St. Michael's. The trip in was something in the order of an hour. Now it's maybe 20 minutes or less from my area.

**Mr. Philip:** It's a lot longer now. It's an hour and a half for me to get downtown in the morning. An hour and a quarter.

**Mr. Kennedy:** Not for me. What I'm wondering is, how do we rationalize having what are described as surplus beds? Are they in a holding pattern, or is it a vacant room where you could put 1,200 or 1,300 beds? Are you familiar with that situation?

**Mr. Story:** Mr. Kennedy, I'm not knowledgeable in what you're referring to. The figure used is the Ministry of Health's figure. This was published by them in November, circulated to all the hospitals, and I have had some grounding through the Hospital Council of Metropolitan Toronto on how it was prepared, but I don't know the answers to what you have given there. I'm not familiar with the detail, nor would I want to be. I think that there is a problem—I've heard there is—relating to the centre core. I don't know. You see, our problem out in the borough is everyone hangs their hat on this, but nobody tells us what's going to happen.

**Mr. Kennedy:** You mention the doctor-patient relationship, and we had some witnesses in last week and I asked a specific question as to whether a doctor is identified with and works with only one hospital, or could it be several, depending on the needs of a patient, and I believe it was the Ontario Hospital Association people who said, "Well, there's no great problem this way." Say if there are vacant and available beds in Metro, I understand, I think as well as anyone, the pride of having your own hospital and the intense interest by the community in having it, but is there, if you like, if there are empty beds located relatively near, a human problem in having the health service provided to the patient by utilizing those that are surplus?

**Mrs. Dowsett:** Perhaps, Mr. Kennedy, if I could reply to that, some physicians do have privileges in more than one hospital. The likelihood, as it happens, with our obstetricians and gynaecologists in our hospital, so if you can relate to the obstetrical service and our problem with maternity beds, do not have privileges at any other hospital. So that if that patient arrives at our hospital to deliver her baby and we don't have a bed

we can transfer her to another facility, but her physician has to transfer her to the care of another physician.

**Mr. Kennedy:** It's a referral situation.

**Mrs. Dowsett:** In other words, the bed may be there, but the bed with the doctor that the patient wishes to have attend to her at this particular point in time is not. The same kind of situation can occur with medical-surgical patients. A patient who has, over a period of years, been treated by a specific surgeon for a problem does not want to go elsewhere to have another surgeon do it, and although there are some cross appointments you can't always depend on the fact that that surgeon is going to have a cross appointment in the hospital where the bed is available, particularly, when you're dealing with a community such as, say, Etobicoke. Probably if they did have cross appointments between our hospital and Queensway, Queensway would be in the same situation as we were at that particular point in time. So perhaps St. Joseph's is the next point of reference.

**Mr. Kennedy:** I see. So you don't really see where there are surplus beds taking a great deal of pressure from Etobicoke General. You know, in Mississauga Hospital when we were—

**Mrs. Dowsett:** For emergencies, sir, it's one thing, but when it's the citizens in your community being treated by their physicians and having access then to the hospital facilities that are available to them, that's wherein the problem lies.

**Mr. R. F. Johnston:** A supplementary to that, if I could: Is it the case that when you have this pressure on elective beds the doctor would either hold on to that person and book them later, as it were, and not transfer them downtown, or try to book that person on an emergency basis in order to get them in and get them a bed? Are those two possibilities?

**Mrs. Dowsett:** Well, ultimately that's the kind of thing that happens. If a hospital restricts the number of elective bookings because of the pressures on it, then over a period of time what you find happening is those elective patients become urgent and then shortly they become emergent. So then they're coming in through your emergency and building up in exactly the same way, so although you may control your problem for a short period of time by controlling your electives, eventually what is going to happen is those patients are going to become emergencies and you're going to be back in the same situation again.

Then you're in the situation of sending your patients, who are coming in through



emergency but who belong to your doctor—it's one thing to transfer a patient who comes into your emergency department without a physician and you don't have bed facility for them; you can make arrangements and you can transfer them to the care of a physician in another institution, but if they're your patients, it's very difficult to do that.

**Mr. R. F. Johnston:** I wonder if I could ask you just to continue on that as far as risk goes. We have a case that was raised in the House a while back of a doctor in Hamilton who in making his physician's decision that had to be made, in fact decided not to go that route, not to put pressure on his hospital, but to wait, and in fact the woman died. He might have been better to have made the decision that it was an emergency, but he didn't. What is your assessment of risk, that this kind of situation accelerates? [5:30]

**Mrs. Dowsett:** The unfortunate part of that is that very often you don't know what the risk is until the problem has occurred. You have to rely on medical judgement in relation to that. There are going to be more and more risks taken as the pressure mounts up, and perhaps more and more situations occurring such as you have just mentioned.

**Mr. Philip:** Could I just ask a supplementary? Just approaching it from the other end, once a physician does have the patient in the hospital, I found that there are a number of people who come into my riding office—and I have dealt with your social workers—and those people want their own physician, and their physician wants them transferred to a convalescent hospital in the area. Is it not your experience that it is very difficult often to get people beds in Our Lady of Mercy, and some of the other convalescent hospitals that are in the area, because of specific problems, rebuilding problems, and things like that?

**Mr. Story:** I'd like to point out that there had been statements made about hospitals having 30 per cent of their patients waiting for transfer to chronic units and nursing homes and other areas. This is not the case in a hospital under pressure. If we had five per cent, we'd be in trouble because we have to keep the beds moving. But one of the things that we have is people who are awaiting placement to nursing homes, chronic or rehabilitation units, but we have never had too much difficulty because when the pressure is on, everybody works together and we do get them out.

In the interest of the patient, our waiting periods have not been that long. But where

we have 10 or 12 patients at any one time who are in the process of moving, another hospital, such as one adjacent to us, has maybe 30 in the same position. It depends on the area, because south you may have a larger percentage of older population, such as in the Queensway area, which could create more difficulty in that hospital, which it did.

**Mr. Philip:** I am finding that I am having an increasing number of senior citizens coming to me, or families having problems with commuting to see their loved relative at a nursing home or a chronic-care hospital that is miles from the community. Would you not say that that puts additional pressures not only on the family, but also on the patient in his recovery process? For example, take the case of somebody who has suffered a stroke and needs the family to encourage him to gradually redevelop his abilities?

**Mrs. Dowsett:** Mr. Philip, if I could speak to that. Yes, that happens. Mr. Story mentioned that we don't have too much of a problem with longstanding patients in the hospital. Our length of stay shows that, simply because one of the things that we do is that, as soon as the patient is admitted, and it looks as if this is going to be a placement problem, we begin to work on it on the day of admission. Consequently we have to turn our patients over. We are also one of the highest percentage users of home care in Metropolitan Toronto, perhaps not in numbers but certainly in percentage of patient activity.

But one of the things that happens in terms of placement is to find a placement agency. There is rather a limited number of placement agencies for the varying and different kinds of resources that you are looking for within the borough of Etobicoke. So your Etobicoke citizens, who are requiring replacement, very often do find themselves at a fair distance from their home base and from their families. That is, in fact, true; that the distance they have to travel to see them is simply because there are not, within the borough of Etobicoke, that many agencies where we can place the patients.

**Mr. Kennedy:** I was just going to remark that when we have this number of surplus beds, and I suppose the capital cost of new beds is something in the order of \$30,000 or \$40,000—I know it used to be \$20,000—depending on the service provided, it just makes you wonder, if you are into so many millions of dollars. It's not quite the situation with you because, of course, you have a roof on and the space located there.



I just wanted to ask a question about your so-called catchment area; you mentioned 30 or 32 per cent came from Malton area.

**Mr. Story:** Malton-Mississauga.

**Mr. Kennedy:** Which Mr. Jones tells me is pretty well built up now.

**Mr. Story:** We cover down to about Bloor North and over to highway 10, and all the doctors of Malton are on our staff.

**Mr. Kennedy:** Do you go to Bramalea at all, Bramalea and around highway 7?

**Mr. Story:** Yes, we do. A lot of Bramalea and Vaughan.

**Mr. Kennedy:** That's booming up in there, yes.

**Mr. Story:** And even north of there. We find an awful lot of specialty referrals up north, as far north as Markdale and Walkerton, to specialists.

**Mr. Kennedy:** What specialty?

**Mr. Story:** Gynaecology, internists for intracranial—these are being referred to specialists at our hospital.

**Mr. Kennedy:** They are special to your hospital.

**Mr. Story:** And some in psychiatry recently, as well, referred from doctors to the north of us because the specialists are located at our hospital.

**Mr. Kennedy:** I guess if you are in the specialty field it wouldn't stabilize as much as it might otherwise if the population stabilized, because I presume the Etobicoke General, other than some renewal replacement and so on, is pretty well stabilized.

**Mr. Story:** No, no way.

**Mr. Philip:** No way.

**Mr. Kennedy:** It's not? In any event, what do you see above and beyond this capacity for 508 beds?

**Mr. Story:** At the present time, the planned rate of this population growth is going to tax the total facilities of our hospital, and we must be ready and have beds available and be funded for opening, and we need these beds now. We can't look at that. But beyond that, the shell was established to put two new floors on this building that we have now, so it could go up to 710 beds.

**Mr. Kennedy:** Over and above the 508.

**Mr. Story:** That's right. The basic facilities were established for 710.

**Mr. Kennedy:** I see.

**Mr. Story:** It could be modified for that and that was in the initial planning when it was done between 1965 and 1968.

**Mr. Kennedy:** Just one other thing caught my eye and maybe you could comment on it. In the annual administrator's report, the very last words on page one—there are two pages—are "unrequired services." Could you just clarify that little point there?

**Mr. Story:** Which report are you referring to?

**Mr. Kennedy:** The administrator's.

**Mr. Story:** The blue section?

**Mr. Kennedy:** The blue, and on page one of that the last words make reference to "unrequired services." That sort of caught my eye. The last sentence: "This lends support to our request for expansion for this could be compensated for from within the system by reducing funds provided for unrequired services." What "unrequired services" are funds being provided for? Could you just enlighten me on that please?

**Mr. Story:** This refers to services unrequired downtown.

**Mr. Kennedy:** Are you referring to reducing funds—oh, yes, I see, it's a general statement, yes.

**Mr. Story:** By the way, this is a preliminary draft that was prepared because of the item that is circled. This is a crisis and everyone seems to assume that if you go into outpatient services, there is day care and you are going to save money, but it doesn't occur. You have to absorb the cost and you really get no relief for it, and this is the major problem. And I put this in and it hasn't even been edited. This has not been used yet, but the thing is that that one part, I think, explains more clearly what our problem is. You absorb the cost and you don't get the offsetting adjustment in there.

**Mr. R. F. Johnston:** You should underline the transcript.

**Mr. Story:** I'll put it in red.

**Mr. Kennedy:** Okay, thanks, Mr. Chairman.

**Mr. Jones:** One quick tag on it, if I may, Mr. Chairman, alluding to what Mr. Kennedy was asking.

**Mr. Chairman:** Mr. Jones.

**Mr. Jones:** In the earlier comments or questions about Malton, I certainly know socioeconomic factors are alive and well there that require special needs, and so on, on both sides of the border up in that area, as was referred to by the member for Etobicoke, and that is stabilizing, I suppose, as far as new growth is concerned. It has been very rapid, and, I understand, very intense,

and it is busy. There are a lot of young families moving in and there is the language situation that was alluded to.

But in answer to Mr. Kennedy I think you said you went down as far as Bloor. Is that what you said?

Mr. Story: We have patients from Bloor and highway 10.

Mr. Jones: Is that fairly intense? Because that's certainly a growth area, north of Dixie.

Mr. Story: No, we actually get patients from Bloor and right across and there is a line more or less up the Dixon Road.

Mr. Jones: To Burnhamthorpe?

Mr. Story: No, it goes over to about the borough of Etobicoke north at the line that goes up a zig-zag line and comes out on that corner where Humber Hospital is on Weston Road. There is sort of a divide and the people gravitate; the doctors, one way, and the others gravitate the other way.

Mr. Jones: I guess maybe the Credit Creek is something of a dividing line.

Mr. Story: Yes, that's what I was thinking of.

Mr. Jones: All right. Then, is it possible, and I guess you have turned your mind to it, that the new hospital proposed for West Credit, although it is west of the Credit River is likely to ease some of that? Taking into consideration the new roads, Burnhamthorpe, for example, where a bridge is being installed now and highway 403 and all these other cross-roads?

Mr. Story: I don't believe, due to the planning process just getting under way and the funding that was recently provided, that this, even if they decided today, could come on stream within a five-year period. Therefore, we are faced with a problem of providing services in a rapid-growth area. I think the Peel District Health Council presented a report which spells out the growth factor at our hospital and the problems, and suggested that the growth must be our way until such times as that can be allowed for, because even in the planning process, in the development of the hospital, you don't do that in one year. By the time it gets constructed it will probably be three years from the time the contract is let, so you are looking at five years at a minimum even if you start at full blast right now. Our problem is now, the growth, and the future growth north of us.

Mr. Jones: I appreciate that. You understand I was a tag on to Mr. Kennedy's comments about the future beyond your present problem.

Mr. Story: I don't think that by the time we get to it, that will give us any relief. It will take off additional expansion that will come about the fifth year onwards, if it is developed for that time. To give you some idea of the growth of our hospital, by the way, it was sitting out in the fields in 1972 when it opened. If you look out of our 10th floor windows right now you can't see any fields except behind Humber, because it's all closed in and there are highrises and buildings that are quite noticeable.

Mr. Chairman: Thank you very much, Mr. Story and Mrs. Dowsett, Mr. Worsley and Mr. Young, for presenting your case to the committee. We have kept you longer than perhaps we should have. We hope we haven't inconvenienced anyone in so doing.

Mr. Story: It's a pleasure to be here and it's the first time I have ever been invited. I have usually had to ask to attend and quite often I got a "no" from different committees. In 35 years it's the first; we've enjoyed it, and it's good to see you again, Mr. Gaunt, and see a few faces from out of the past. Thank you.

Mr. Chairman: Thank you very much.

There is just one item I should raise with the committee, and that's the tentative schedule we have set up for June 13. That's our travelling day to Ottawa, Windsor, Thunder Bay and Sudbury. You will note that there are a lot of spaces in that agenda. Many of the hospitals have indicated that they will not likely attend. As a matter of fact, if we run down the list, Ottawa-Carleton Regional Health Council has certainly suggested that we meet with it and it is quite happy to meet with us, but other than that there are no hospitals which have indicated a desire to meet with our committee. The same applies to Windsor and to Thunder Bay, and basically the same applies to Sudbury, and I am wondering whether or not that particular day would be better spent doing something else, perhaps around here.

Mr. McClellan: I wonder if we could think this over overnight and maybe pick it up at the beginning of the session tomorrow?

[5:45]

Mr. Chairman: Yes, agreed. I think that's a good idea. I just wanted to raise it with the committee, Ross, to alert you as to what was happening because it looks as though, unless we have some fillups quickly, it's not going to be worthwhile.

Mr. Kennedy: Let's see, we are through with witnesses coming here until next Monday.

**Mr. Chairman:** Yes.

**Mr. Kennedy:** Yes, that's because then we are going to take the next day probably, or the day after.

**Mr. Chairman:** Yes. We can think about it overnight and discuss it tomorrow.

**Mr. Kennedy:** Maybe we can "button her up" next week.

The committee adjourned at 5:46 p.m.

## SPEAKERS IN THIS ISSUE

---

Blundy, P. (Sarnia L)

Gaunt, M.; Chairman (Huron-Bruce L)

Johnson, J. (Wellington-Dufferin-Peel PC)

Johnston, R. F. (Scarborough West NDP)

Jones, T. (Mississauga North PC)

Kennedy, R. D. (Mississauga South PC)

McClellan, R. (Bellwoods NDP)

Philip, E. (Etobicoke NDP)

Ramsay, R. H. (Sault Ste. Marie PC)

**From Etobicoke General Hospital:**

Dowsett, Mrs. M., Assistant Administrator, Patient Services

Story, A. T., Administrator

Worsley, A., Associate Administrator













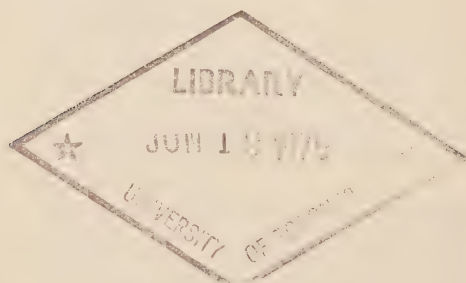
No. S-22

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Tuesday, June 5, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.

Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

TUESDAY, JUNE 5, 1979

The committee met at 3:30 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (continued)

**Mr. Acting Chairman:** Gentlemen, we'll get started. Mr. Murray Gaunt, your regular chairman, phoned in sick today. I don't know what he's sick of. Somebody said he was at a caucus earlier this morning, but he phoned from his apartment and said he was unable to be present—for health reasons.

Just before we hear the brief scheduled for today there are a couple of matters I think we should dispose of very quickly, if possible. If you recall, last night we carried over until today our decision about what we would do about our visits to the various parts of Ontario next week. To sum up the response, there was one positive response from Ottawa; there was no response from Windsor; there was one from Thunder Bay; and none from Sudbury. This is regarding trips by a subcommittee of three or four which will go to each of these places.

This can be handled in two or three ways. If you have any input you'd like to make now, please do; if not, perhaps we should let our steering committee meet briefly before tomorrow's meeting and make some decision so we can let these people know if you're planning on going. Is there any comment right at the moment?

**Mr. Breaugh:** I was going to suggest, Mr. Chairman, that we refer this matter to the steering committee and let it meet at one o'clock before the meeting tomorrow and make some recommendation to the committee in the afternoon.

**Mr. Acting Chairman:** Is that agreeable?

**Mr. Breaugh:** I'm having a little difficulty understanding why hospital boards who say they have serious problems, and some are saying it before a court, are reluctant to appear before a committee of the Legislature.

I think we'd best leave that to the steering committee.

**Mr. Kennedy:** They know who's on it, that's why.

**Mr. Conway:** I would support that very much, Mr. Chairman, and I think we might

profitably add to it an event that occurred in my absence last evening.

**Mr. Acting Chairman:** Yes, we'll bring that up next. Are we agreed that one matter should go to the steering committee?

**Mr. Kennedy:** Yes, that's acceptable. A good plan.

**Mr. Acting Chairman:** The other matter has to do with what happened in the wee House last night. When the report was presented to the House for debate, it was recommitted back to this committee for reconsideration. That is the way it was worded. Can we do the same thing with that? How shall we proceed with that in the future? Do we have any comments at the moment?

**Mr. Breaugh:** I agree to that. Send it off to the steering committee.

**Mr. Conway:** I think the steering committee might profitably look at that tomorrow, as well.

**Mr. Acting Chairman:** Agreed? Okay, both those orders then will go to the steering committee.

**Mr. Conway:** It will meet at one o'clock tomorrow in the members' reading room. Is that all right?

**Mr. Kennedy:** Fine.

**Mr. Acting Chairman:** Mr. Breaugh, you'll be on that, as it has been Mr. Lawlor.

**Clerk of the Committee:** No, but not on this subject. On the bed closing it's been Mr. Breaugh and just for Lakeshore it's been Mr. Lawlor.

**Mr. Acting Chairman:** You can work that out. Okay, the steering committee will meet on those two items tomorrow at one o'clock.

We're very pleased to have with us this afternoon two representatives from the Scarborough General Hospital. On my right we have Mr. McCarthy who is the administrator of the hospital and who will be the main spokesman, I guess, today; and his assistant, Mr. Allan Greve, on my left. Gentlemen, we welcome you here and, if you'd care to make a presentation then some of the members may wish to question you about various matters.

**Mr. McCarthy,** you may stay seated.



Mr. McCarthy: Mr. Chairman and ladies and gentlemen of the committee, when Mrs. Gibbs and Mrs. Nokes spoke to us last week, we were pleased to have the opportunity to come. Naturally, we didn't have anything prepared. Mrs. Nokes undertook to circulate—and it was circulated, as I see—a copy of a letter which we recently submitted to a committee that's studying beds in our area. Then we got busy and thought we should put down a few words to elaborate a little further, and we've done so.

I don't want to bore you; some of it is kind of repetitive, but there are only a few pages. I'll read through it and will be most pleased to try and answer any problems or questions it raises.

Mr. Chairman, as I said we're pleased to have been invited. We have considerable experience in a large and complex hospital in the extensive and rapidly-growing borough of Scarborough, which constitutes the north-east sector of Metropolitan Toronto. Scarborough, as you may know, is the only area in Metropolitan Toronto not yet fully developed. Scarborough General is a public non-profit corporation governed by a 22-member board of 12 elected and 10 appointed governors. It has a paid staff of 1,475; an auxiliary of 300 active volunteers; an active medical staff of 105 specialists in 15 specialties; 105 general practitioners and a further 174 courtesy staff members.

It is one of three hospitals located in the northeast. The area it draws from we believe exceeds 40 square miles, with an estimated population of more than half a million. These three hospitals—I've noted it there—are Providence, which is a chronic care and rehabilitation hospital; Scarborough Centenary, which is an active-treatment hospital; and ourselves. Over and above service to people in the basic area, Scarborough General cares for some patients referred to members of specialist staff from elsewhere. Such referrals are most significant in specialties: neurology, neurosurgery, plastic surgery—including burns—and ophthalmology. Patients and staff provide an opportunity for clinical experience to graduates, undergraduates and postgraduates of medicine and to students in nursing and other health professions.

The first sod for Scarborough General was turned in 1954 by Fred Gardiner. At that time, the area was just developing and it has continued to do so since. The hospital was expanded in 1960 to 340 beds; in 1968 to 639 beds; and in 1974, with the addition of the long-term care unit, to 807 beds in total. Because the area growth has been so

rapid and persistent, hospital bed ratios have seldom been maintained at ministry guideline levels. A comprehensive study of beds and other health facility needs in the Scarborough area was recently done, and we are very pleased the ministry made the funds available to do this. We think it was needed, and it's going to be enlightening and will answer a number of questions.

The periodic reports by the consultants on this study were available to us, but we haven't seen the final report. Our interim response by letter to the chairman is attached and, I think, was circulated. As noted in our letter to Mr. Cornwell, the chairman of that Scarborough committee, we urged highest priority be given to providing operating funds sufficient to permit optimum use of existing beds and facilities, rather than to sinking further money right at this time into more beds or more bricks and mortar. With very modest bricks and mortar or capital expenditure and relatively small increases in operating funds, we believe the necessity of providing further beds in Scarborough could be postponed for at least a few years, despite the growth going on there.

We noted the minister had identified four goals and objectives of his ministry and these are, we think, very laudable goals. The first one was the development of alternatives to active-treatment care. We think much has already been done there; we don't say everything that could be done has been done, or everything that can be done has been done, but we think quite a bit has been done. More would be desirable, but if our situation is typical, the shortfalls in reimbursement of the past few years are a serious obstacle to progress in this regard by hospitals. Hospitals, as you know, face open-ended demand on them for services and with shortfalls in funds it is a mistake to believe that hospitals can do much more to achieve that number one objective.

As reported in the attached statement of information by our board of governors—that's attachment number six, right on the back sheet of the package—we have done everything possible to ensure we're operating at maximum efficiency and effectiveness. Comparative data, both from the ministry, which is attached as item five, and another comparative data survey attached, item four, confirm that in fact, Scarborough General is operating efficiently and effectively, and we recently undertook with the help of management consultants a zero-base planning and budgeting program which we're now implementing. I think it's the consultants' opinion, and it

certainly is ours, that if there was any doubt about the fact that our operation is fairly strained, this has removed any such doubt.

The Ministry of Health is the financing and reimbursing authority for hospitals. We feel that if its reimbursement of a particular hospital permits greater progress towards those objectives, such goals should surely be identified and made a priority. The ministry's second and third objectives are, like the first one, laudable, the second and third being personal responsibility for health and disease prevention. We believe your committee would be interested in examining the program that the ministry has for this purpose, the expectations of that program and the accomplishments that may have been achieved there.

As you know, greater personal responsibility for health care is much talked of. If achieved it would permit major cost-saving measures through reduction of demands. Suppliers of service, such as hospitals, are only one side of the cost equation. We are encouraged that the ministry is looking at the other side, namely, user demand. We would be very interested, as we believe would your committee, in knowing more about programs by which users of service would be encouraged to take more personal responsibility for their demands, and thus hopefully reduce those demands, on health services.

The fourth objective is likewise commendable and we are grateful that the ministry has provided funds to determine the facts in our area, and this is the Scarborough study that we refer to. A patient origin study done by the Ministry of Health indicates that about 57 per cent of Scarborough's population and about 59 per cent of Markham's population are served by the two Scarborough active-treatment hospitals. This could reflect a combination of patient referral patterns, mobility of patients or, more likely, the lack of resources and funding to provide sufficient health facilities in the form of active-treatment care, emergency care, ambulatory care programs, psychiatric programs, outpatient mental health facilities, et cetera, to meet the needs of this large population.

It is realistic and practical, we think, for the people of Scarborough and the adjacent catchment area to receive their health care, as far as possible, in the community in which they live. In our presentation to the Hospital Council of Metropolitan Toronto, presently acting as the interim district health council for Metropolitan Toronto, we stressed that this could most economically be achieved for the immediate future by adequate and equit-

able operating funds for optimum operation of existing facilities and with only modest capital expenditure for a few renovations.

[3:45]

In the case of our hospital, these renovations were the expansion or renovation of our emergency department and outpatient facilities. This is a large facility. It's very crowded. It was not designed for the number of people it is now handling. A lot of patients receive primary care there, and some secondary care. In outpatients, the second thing we requested was something that a report by a ministry official, Mr. Singh, in 1977, had indicated was badly needed in the area, and this was additional outpatient mental health facilities. The Agnew Peckham consultants, who were consultants to the Scarborough study, have confirmed that again in their surveys, and we really feel this is necessary. We can't do it any more with what we have. We're merely doing the best we can, but some additional facilities are required in that area.

Chronic care: The minister stressed the desirability of chronic care as an alternative use of active-treatment facilities, an alternative which he felt and believed would be more appropriate for many people, and also less costly. We concur in that, and our hospital, with the ministry's help, as you know, has a 168-bed chronic-care facility built in 1974.

We've discovered a small feature of that operation which we've asked for a change in, and this is simply a change in terminology rather than a program. It's a change by which some of the beds, approximately 40 of them, would be reclassified from chronic to rehabilitation. We can go into this question later. It's a very small change. The strange thing about change is we don't often discover something that's going to produce more revenue for the ministry, or for hospitals, but this would produce a small bit more revenue just for a change of categorization by the ministry.

These are our views, Mr. Chairman, based on our experience. We will be pleased to provide any further information which your committee may request.

**Mr. Acting Chairman:** Thank you very much, Mr. McCarthy, Mr. Warner?

**Mr. Warner:** Mr. McCarthy, it's a pleasure to see you again, and I certainly could, for the benefit of the members, just stress that this hospital, while it's located in a suburb of Metro Toronto, functions as a downtown hospital. It has 100,000 visits a year through the emergency ward, has a full range of services, including neurosurgery, and the hospital



is very proud to say that the person who helped stimulate such a fine neurosurgery department was one, Dr. Bob Elgie, who has gone on to other pursuits.

**Mr. Conway:** David, those of us from outside Metro assume that Scarborough is downtown Toronto.

**Mr. Warner:** Ah, very good.

**Mr. R. F. Johnston:** It's the centre of the universe.

**Mr. Warner:** Certainly the cultural centre of the world.

**Mr. Conway:** Which is not unfolding as it was supposed to.

**Mr. Warner:** I had a couple of questions. You've mentioned the study by Mr. Cornwell, or at least he was the chairman of whatever group was doing this study. Do you know when that final report should be available?

**Mr. McCarthy:** Mr. Chairman, it is my understanding that it would be available in June. Of course, it's not to be available to us, it's to be available to the Hospital Council of Metropolitan Toronto initially, which is acting as the district health council.

**Mr. Warner:** Then they forward you a copy of it?

**Mr. McCarthy:** I would think so. We haven't received anything yet. We receive periodic progress statements by the consultants. We haven't received anything from Mr. Cornwell.

**Mr. Warner:** Can you tell me what the bed ratio is at this point?

**Mr. McCarthy:** I haven't got it in front of me. That was covered by the Scarborough study. My own impression was that it is down to or below the 3.5 active-treatment level that the minister set as its target I think for 1982. The present target as you know is four, in our area. I don't think Scarborough was ever, for very long, at four; it's always been below that.

**Mr. Greve** pointed out that we did have the figures. This was the Scarborough study.

**Mr. Greve:** Those are extrapolations based on a population of half a million in the catchment area—and in fact, you usually have to know that catchment area for these two hospitals, the active-treatment hospitals in Toronto. If we used the catchment area figure of a half million people that we have mentioned in our brief, then applying the bed ratio for Scarborough, for the present two active-treatment hospitals it would be around 2.5 beds per thousand.

**Mr. Warner:** Correct me if I'm wrong, but the bed-ratio figure applies to Metropolitan

Toronto. They also deem that there are extra beds in the city of Toronto. Therefore, in order to level out the figure they want for all of Metro Toronto, it will be necessary for Scarborough to live with something less than the four.

**Mr. McCarthy:** Mr. Chairman, this point was made by the minister last fall. I think the committee can get that document. There were some facts presented.

It's my recollection—we're speaking of the future—that to get down to the 3.5 level would mean that there were something like 1,200-plus surplus active-treatment beds in Metropolitan Toronto. As you can see, for Scarborough to get down to that level wouldn't require any change, because we've been there. The method that was suggested—and again, I don't want to speak for the minister on it—but the thought that was presented was that 1,200 beds would be allocated. The surplus would be allocated throughout on a proportion basis to every hospital.

We don't feel that would be the best way of doing it, although we certainly have some sympathy with the government's attempts over the years to try to resolve the surplus beds problem that exists in downtown Toronto. But if a proportion of this reduction of 1,200 beds is allocated to Scarborough, there will be funding for some 40 to 50 fewer beds, I suspect, than there are presently funded. We don't believe that in this kind of growing situation people really should have to look at the downtown area for hospitalization which is given and which could be given closer to their residence.

This isn't to say that the Scarborough area doesn't depend on downtown Toronto. Despite what Mr. Warner may have told you, we consider some of the teaching centres are referral centres and these hospitals are essential to make the system work in Scarborough. We take a few people from beyond the boundaries and we become a referral centre for those people, but we in turn put demands on the downtown hospitals to accept referrals.

**Mr. Chairman,** I believe the matter is very difficult. We people in Scarborough may be a little narrow in our view, but as residents, we don't believe that we should be saddled with the burdens that have built up in the downtown area.

We shouldn't be saddled with these in terms of the Scarborough population. That opinion isn't just ours, Mr. Chairman. I think all hospitals in Scarborough have expressed that and the medical officer of health. There have been several letters, both to the Hospital Council of Metropolitan Toronto and I think to the Ministry of Health, in that regard.



So far the ministry does not believe it can segregate Scarborough from the rest of Metropolitan Toronto without reducing the possibility of handling that surplus. I don't know how it's to be done, but we don't think it's the best thing for us.

**Mr. Warner:** There is one other item I wanted to ask you about; something I'm very concerned about. My understanding is that Scarborough General is one of the few referral places for nursing homes and other homes for the aged and so on for some travelling distance. Seniors come from—I'm not sure how far away, Port Perry, some distance outside of Scarborough at any rate. I don't know if you can give me a figure as to how far they come, but when they do, because of the pressures that are placed on the hospital, particularly your emergency ward, in not having strictly a clinic facility as well as emergency, through the hospital's necessity those elderly people have to wait for a while, for a long time, unless it happens to be an actual emergency.

**Mr. McCarthy:** Mr. Chairman, I think what Mr. Warner is referring to is the fact that it was covered in, as you'll see when you get it, the Scarborough committee report. The ratio of nursing home beds in Scarborough is relatively very high compared to what it is in some other areas. There are also some nursing home beds just beyond the political boundaries. It's because of the number and proximity of these that the hospitals in Scarborough, I think, become the first place for people from nursing homes where they are thought to require active treatment. This does add to the demand on the hospitals, more so than would be expected if you just looked at the community itself.

The nursing homes have come into the area because it was the only area I guess where the land was reasonably priced, and there's a disproportionate number of them. The patients in those nursing homes are not necessarily previous residents of Scarborough, but they've come into nursing homes and this does add to the number of elderly people who thereby tend to be heavy users of hospital care. They do come to our emergency department in quite large numbers. That's fine; I think they should be coming, if they have to be hospitalized. But they do put a burden on a place that was really never planned for that burden. That's the problem.

**Mr. Warner:** I'll close off for now, Mr. Chairman, because I know others will have questions. All I can leave with the committee from having spent an entire day visiting the hospital—and these gentlemen were kind enough to give me the information I wanted,

and I spent some time in the emergency ward and so on—is there is absolutely no question that the level of care over a period of years has suffered because of the cutbacks.

The staff couldn't work harder. The staff couldn't deliver more than they're doing now, and the quality of the staff is first rate. They're overworked to the point of almost being absurd. If you stop and think about 100,000 people a year, or roughly 275 people a day, coming through very cramped quarters in the emergency ward, how you can deliver a good quality of care without avoiding serious problems occurring, I think is just a miracle that the hospital has been able to function the way it has.

[4:00]

Unless a proper level of funding can be restored to take the pressure off the staff, we're in for more problems than we've got now. I commend the hospital in having been able to do what it has done to date without there being serious problems. I don't know how they function, I really don't; but they have. I don't think it can go on much longer. I had a letter from a nurse at the hospital who quit after a while. She said she just couldn't take the pressure any longer, because the conditions had deteriorated, through no fault of the hospital's. It's just strictly this government which appears determined to undermine the health-care system.

**Mr. Acting Chairman:** I appreciate your appearance and certainly the information you've given us. Mr. Pope.

**Mr. Pope:** Thank you, Mr. Chairman.

Sir, you refer to 100,000 visits in both your emergency and your outpatient facility. Do you have a breakdown between the two?

**Mr. McCarthy:** Yes, we could provide you with that. I don't know if I have it here, but it's my recollection that about two thirds are people who come seeking emergency attention; the rest are people who are scheduled to come back. For example, our cancer chemotherapy has become quite large and since we really don't have any other entrance for patients to come through and we don't have a facility for handling those booked-out patients, they come through the emergency department. They're not treated in the emergency department; they're not held there, but they are processed through there. That's an example, but roughly 25,000 to 30,000 people come as booked patients.

**Mr. Pope:** And how many times a year would these people come in for their chemotherapy or their treatments?

**Mr. McCarthy:** I just don't have exact figures at my fingertips, but you would have

to average it, because chemotherapy is something where my treatment might be every six weeks, somebody else's might be every two weeks, and so on. I think about 400 patients are in chemotherapy at the moment; they make up some part of that 30,000.

Other people are coming back for fractures; people who have come in for emergency fracture treatment come back and have their cast checked in the cast room. Those are booked patients. We also have a facility there for doing surgery under local anaesthetic, and some proportion of those are booked for that procedure. We also have our cystoscopic rooms in that area; some of those are emergency and some of them are booked patients.

I could give you the exact breakdown. We do have it but I don't have it with me. I'm sorry.

**Mr. Pope:** Yes, that would be fine.

**Mr. McCarthy:** We'll send it to the chairman.

**Mr. Pope:** It probably would help us to determine the true pressure on your emergency unit as compared to your outpatient facility.

**Mr. McCarthy:** Mr. Chairman, Mr. Greve will speak. He's found the figures from last year.

**Mr. Greve:** I have the figures for last year. There were 97,081 visits the previous year, and in the fiscal year just ended there were 100,000, so I'm giving you the past year's performance. The non-booked people who visited the emergency department in that year numbered 81,000 of the 97,000. So if you subtract, in that particular year there would be 16,000 booked patients and the rest were people who came to the emergency department because they thought they needed some type of care. The hospital did not ask them to come to the emergency department.

In the emergency department are, as Mr. McCarthy said, chemotherapy; the plastic clinic; the fracture clinic; the endoscopic things that we do such as colonoscopes, gastroscopes and things of that nature; plus the minor surgical procedures under local anaesthetic; and in addition the revisits for the pacemaker clinic. People who have pacemakers inserted come back for a recheck to see if the battery value is still there to keep the pacemaker viable. That's the previous year's performance.

**Mr. Pope:** So it's about 16,000 booked and 81,000 unbooked.

**Mr. Greve:** That's true.

**Mr. Pope:** Okay. You mention in your letter of May 23, 1979, to Mr. Cornwell, "The board of governors wish to record with your committee the following priorities," and you talk about active-treatment beds being at 82 per cent occupancy. Do you have a breakdown of the occupancy rates between wards?

**Mr. Greve:** The hospital does have them, not here. It varies all the way from near 100 per cent in the medical floors to relatively low in the obstetrical floors or the paediatric floors. It's a span of things on the different specialties.

We could give that to you but it fluctuates, depending on what comes through the emergency department also, what season of the year it is and all these factors. There's a number of factors that will come to play in that particular issue.

**Mr. Pope:** Would you have any idea of the number of nights in which you're unable to place someone in the medical, men's surgical or women's surgical floor?

**Mr. McCarthy:** Mr. Chairman, it's very rare that we would ever transfer a patient we were capable of looking after. I'm thinking there of medical capability. While it was never planned for 100,000 the facility was a kind of comprehensive place. It has a large, neat, 10-bed recovery room, which is really there to serve patients who are having a general anaesthetic in fracture or in cysto or recovering from a local anaesthetic in the local surgical area. These patients, if they couldn't be admitted right away, would be held in that area until a bed is freed up in the morning. It's really almost a nightly occurrence that patients are held there until a patient can be discharged from an area in order to let them in. That applies in the medical beds more than almost any other beds. I distinguish medical from surgical.

In the department of medicine upwards from 95 per cent of our patients are coming through emergency. There's almost no such thing as an elective medical admission.

It isn't the same in surgery. About 50 per cent of our surgical admissions are elective. Where crowding occurs, for example, is if you had expected to have a number of surgical admissions the following day and you were flooded with medical patients; you'd simply have to either discharge some to get some in or you'd have to cancel some of the elective surgery in order to accommodate that rush. That's how it works.

**Mr. Pope:** There's a special ward of eight to ten that is holding space?



**Mr. McCarthy:** It wasn't intended to be that, but it can serve that function because it's an area with, well, not very comfortable stretchers; no stretcher is very comfortable.

It was intended to be sufficient for people recovering from anaesthetic for a reasonably short period of time and it does function as a holding area until a bed can be freed up. But as far as transferring a patient to another hospital goes, most of our transfers are where, in our opinion, the patient's condition requires they go to that other hospital.

**Mr. Pope:** How about the size of your elective surgery list?

**Mr. McCarthy:** I'd say the elective surgery list has roughly 1,000 patients on it.

**Mr. Blundy:** What sort of waiting period would that mean if I were a patient? Two weeks? Six weeks? Eight weeks?

**Mr. McCarthy:** To some extent that's going to depend on the surgeon and his particular waiting list. I did have some data on that; we could provide it.

Not every surgeon has the same length of waiting list. Some surgeons have relatively short lists, some have relatively long. I would think about four to six weeks would be about average for elective work.

**Mr. Pope:** Do you know how your occupancy rate stacks up against other hospitals in the province?

**Mr. McCarthy:** Yes, there is probably data on that. Ours is on sheet four, which we attached there. There is some data which we presented to our board last year. It was for the period ending December 31, 1977, but I don't think it's greatly different.

It was statistics on our hospital's operation compared to similar types of hospitals throughout Canada. Our occupancy was above average on psychiatry and intensive care, average on short- and long-term units. That's covered under item four there.

**Mr. Pope:** Item four. Go ahead.

**Mr. McCarthy:** Occupancy is a funny thing; I guess you know. If a person stayed in a bed for a whole year, that would be 100 per cent occupancy for that bed. If you had 30 patients in that bed during the year for varying periods, you would have a different occupancy. The flow through or the throughput in the bed has a lot to do with occupancy. If you have a relatively static operation, it would tend to be high occupancy. If it's very fast moving, dynamic, it could handle a lot more patients at a given occupancy. In other words, occupancy by itself is only one dimension of the thing.

**Mr. Pope:** How about the occupancy rate on your chronic care beds?

**Mr. McCarthy:** The occupancy rate in chronic care is quite high. I think it's about 95 or 96 per cent, as one would expect it would be. Those patients going into chronic care are screened. There is no such thing as an emergency admission in chronic care; those patients are screened and planning is done for their discharge, so it can run at a high occupancy without presenting the problems that a 95 per cent occupancy would present if you were running active-treatment beds that way.

I think it would be quite difficult in a complex, highly specialized hospital to achieve for very long an occupancy of over 90 per cent. It could be very difficult to achieve. For example, you can't schedule occupancy for maternity or paediatrics. Those are not electives largely.

Many of our units are specialized. For example, we don't put other patients in our cardiac unit. We retain it so it runs at I would think about a 75 per cent occupancy. No matter if we were wanting a bed for a medical patient with another diagnosis, we wouldn't—we would if we were absolutely desperate, but we wouldn't automatically—think of putting him in the cardiac unit because the program of treatment there really wouldn't be appropriate. So the more specialized you are the less flexibility you have to deal with total occupancy.

[4:15]

**Mr. Pope:** Does the thought behind a re-classification of chronic beds—I gather we call it general rehabilitation beds—have to do with access to physiotherapy and things like that?

**Mr. McCarthy:** It's really a very simple thing. Under the preferential insurance—Blue Cross and other types of insurance—they have traditionally placed a limit on the time, the length of coverage, and the rate for chronic beds. They don't place the same limit on the rehabilitation beds. They're guided by what the ministry says the bed is. If the ministry were to say, as they now say, we have chronic beds, and a patient with differential insurance coverage comes in there—and we have a very good rehabilitation program, there's no question about that—the patient suffers a penalty in coming to our place rather than going for the same type of treatment under a different name to some place where the bed is called a rehabilitation bed.

So it's a part of our system. I'm sure no one planned it this way, but it has developed that the demarcation between the terms "re-



habilitation" and "chronic" is not nearly as distinct as it might have been in the minds of the planners many years ago. When we built the chronic-care unit we weren't aware of this peculiar thing—or we didn't think of it.

We've had patients who protest that their semi-private coverage doesn't cover them as fully in our place as it would in an alternative facility. We can't do anything about that. If people come, we would like them to get as much benefit as they can out of their insurance; we would benefit modestly and so would the government from that share of the differential. But we can't do that ourselves. The beds are categorized by the ministry and we're asking the ministry to simply accept the program as it's there now. It's there. Changing the terminology doesn't change the program. We're not asking for any more beds or for any more facilities, we're simply asking for a change of terminology.

**Mr. Pope:** On page three of your presentation, in the second paragraph, you say: "A zero-based planning and budgeting program which we have undertaken with the help of management consultants removes all doubt that operation is not strained." This was a private management consultancy you engaged?

**Mr. McCarthy:** Yes.

**Mr. Pope:** Did they make any recommendations with respect to costs and efficiencies? Have you implemented them to any degree and what are the savings?

**Mr. McCarthy:** If you refer to item six, the attachment, it is a statement our board prepared at the beginning of this fiscal year, or approximately at the beginning. It was a statement really to essentially tell where we are at, what we're faced with and how we're going to try to manage in the face of the difficulties or the problems that are there.

The deficit that we faced, by our calculations, was a shortfall in funding of approximately \$650,000 and we began the zero-based planning and budgeting program. Our board wanted that undertaken and we've undertaken it so we could identify our priorities. Our plan is that by the end of this fiscal period, March 31, 1980, we would have made sufficient savings or ceased providing certain things, altered our operation sufficiently to be fairly close to have recovered that deficit.

We don't know exactly how well we're doing yet. We just really got started and there's a time lag in this; so when I say we're going to be within that target, every month or al-

most every day that goes by where we have not implemented something, or we haven't got it fully implemented and working, we're losing the possibility of achieving the full annualized target.

We're working on the basis that we had some 49 programs which we identified among some 500 programs we offer—in the terminology or the lingo they are called decision units and decision packages—and which we felt were the lowest priority of our outputs or packages. We don't want to imply, and we tried not to imply, that any of these packages are unimportant. We had them there, they were things we were doing, because we thought they were important. But when faced with ranking the 500 things we identified as decision packages, we had to start at 500 and we ended up with the bottom packages. We intend that the bottom 49 of those are not going to be funded in the current year. So these packages will disappear.

As well, we try to augment income from other than the ministry. We do this through the parking lot, which is run by our auxiliary. After certain expenses, the net of that parking lot is returned by the auxiliary to the hospital. So we do expect to recover some amount of additional money from that source. We intend to implement a patient telephone charge, which we haven't had previously. That has not yet been implemented; we are in the process of doing that. We're asking patients more and more to think of us when they have a few spare dollars around, and through those kind of things we're trying to augment the revenue of the hospital.

**Mr. Conway:** What exactly is a patient telephone charge? Could you describe it very briefly?

**Mr. McCarthy:** There is a telephone in each room which is available for the patients. It's connected to the outside, through the switchboard. We have had that facility, but we've never charged patients for that convenience. We intend to implement a charge for such phones.

**Mr. Conway:** On a hotel basis almost.

**Mr. McCarthy:** We'll just put a flat charge in on the patient's admission. We say we're going to put a flat charge on every admission, which will cover, or attempt to cover, the cost of those phones.

**Mr. Conway:** If I tell you I don't want a phone, do I escape the charge?

**Mr. McCarthy:** That's one of the difficulties we face; it isn't as easy to do. If you say

you don't want a phone, we'll have to negotiate that with you. It isn't as easy as putting a charge on a parking lot, for example. If you don't want to park there, you don't have to. If you don't want to pay, you don't have to; you can go somewhere else. But there is a difficulty there with the phones, and one of the reasons we haven't got this implemented is that it is rather difficult.

**Mr. Conway:** These are the sorts of additional revenue considerations you're now forced to proceed with on the basis of increased operating expenses?

**Mr. McCarthy:** A number of hospitals have had a telephone charge. We've been a little deficient in our revenue-raising efforts before, but we think we'll be on a par when we have a phone charge as well.

**Mr. Pope:** You refer to a catchment area of 500,000. What's your referral population for purposes of negotiating your budget with the ministry?

**Mr. McCarthy:** This report, the Scarborough study, is going to have a great deal of data in it. Also I had a lot of stuff from the preliminary reports which I didn't bring here.

We don't negotiate our budget with the ministry. In the past few years, the ministry has been in the position of having to say it had only so much money. It was allocating this the best way it could on a flat percentage increase to the existing base. So we really haven't negotiated in recent years.

The population of Scarborough is around 400,000, but the catchment area, which draws from the north and the east goes up quite a bit above that—to 450,000 or so.

**Mr. Pope:** So you've had no discussions with the ministry about referral population figures, in terms of your budget, nor have you had discussions about whether or not you have a net inflow or a net outflow—

**Mr. McCarthy:** We must be fair about this. The ministry is concerned about our area, and has been concerned. It did fund a special study which is now just about completed. Its purpose was to resolve those concerns.

Our hospital wasn't able to sit down with the ministry, nor they with us, to say, "Look, we're serving this many people," but they did attack it on a global scale. With the aid of consultants they have attempted to determine the hospital bed needs and other facility needs in Scarborough. That will soon surface.

The ministry made the funds available to what is presently a temporary acting district health council for Metropolitan Toronto, namely the metropolitan hospital council. This

became the vehicle for funding to do that study.

**Mr. Pope:** But before these results are known and before this study got under way, was your budget established on the basis of a referral population system?

**Mr. McCarthy:** Our budget has an historic base, escalated by what the ministry decides upon—in this case around 4.5 or 4.6 per cent. That's the budget for most hospitals this year—an historic base and an escalator.

The historic base originally must have had some kind of validity in terms of population. When beds were first built, they were related to the population. They were built in considerably greater numbers than the ministry now believes are necessary. That's part of the minister's objective—to reallocate these numbers into a better ratio of active, chronic and ancillary services.

We were approved through those many building programs at a certain number of beds. This was before my time, but it must have been related to the population that was believed to be depending on this hospital.

**Mr. Pope:** So you've had really no conversation about referral population since 1974 then. There's been no discussion—it has just been percentage increases in your budget since 1974.

**Mr. McCarthy:** I don't recall that we discussed referral population. I can't say this flat escalator applied in 1974. I don't recall just what did apply at that point. It certainly does apply this year; it applied last year, and I think the year before.

[4:30]

The ministry itself presumably had a limited amount of funds to spend, and has allocated these in a flat escalator to all hospitals. The ministry, in addition to that flat escalator, has in the last few years introduced something which we think is a desirable development. That is the special funding of what is called life-support systems. These are pulled out.

Each hospital has an opportunity to identify which of these systems it is providing or is interested in providing. The ministry, in turn, will allocate a certain amount of money, as much as it feels is necessary or as much as it is able to, to fund these things. For example chemotherapy, which I mentioned before, is a relatively new health service. It is one of the life-support programs that are specially funded. Chemotherapy didn't even exist at our place in 1974. It has grown since then. In the last year or so, the ministry has given each hospital that has a program in chemotherapy, for example, some funds to carry that onwards, over and



above the base budget, and over and above the base escalator.

**Mr. Pope:** And how much has the government paid for those life-support programs in the last year, for instance?

**Mr. McCarthy:** Paid in dollars? I'm sorry. I could be wrong, but I think our recovery through those programs is about \$70,000. That's over and above the money we would have received had we only received the escalator on the base.

**Mr. R. F. Johnston:** Is that for one year?

**Mr. McCarthy:** Yes. Our budget is around \$28 million.

**Mr. R. F. Johnston:** Is the \$70,000 you're talking about there another \$70,000 over and above that which was in the fiscal year prior to it for your chemotherapy?

**Mr. McCarthy:** Yes, this is something that's over and above the base. Now whether that \$70,000 completely reimburses us for the cost of this program is something that won't be known until the year is completed. And if we found \$70,000 wouldn't cover our costs for those programs, we would either have to reallocate money from something else or reduce the volume of service we are providing in those programs. Or ask the government for more money, and the government itself would be limited in what they could provide.

**Mr. Pope:** Are there any other add-ons, above your base?

**Mr. McCarthy:** I'm not aware of them. Mr. Chairman, we think this concept of special funding for programs that are not available everywhere is a good one. We really commend that concept. It's a type of growth that is different in some places from others. We are concerned, or we have some wonderment about how—if we were in the government's position as you people are—to allocate the health dollars to institutions such as ours. The report which the Ministry of Health produces, and which is available, shows how much each hospital has received. There is quite a variation in this relative to what appears to be the output of the institutions. We think the concept of life-support funding is a good one, and one that perhaps the ministry is wise to try to develop even further.

**Mr. Pope:** Do the other two hospitals in the catchment area make use of your specific chemotherapy program, or is this something that's shared, and are you getting into the sharing of some programs and facilities with the other hospitals?

**Mr. McCarthy:** Mr. Chairman, with regard to chemotherapy, Scarborough Centenary,

the other active-treatment hospital, has a chemotherapy program. Chemotherapy is an outpatient program and there would be no saving to be had from sharing. Each patient who comes for a treatment and, for example, has an intravenous or some kind of a chemotherapy drug, is taken care of in an area we have modified slightly to handle them. This is a rather crowded area but it's adequate for the purpose of a few hours or up to four or five hours; they remain there for the day or for part of the day. I don't believe we could handle any more patients than we are handling now. And I don't believe that Scarborough Centenary could handle any more chemotherapy patients.

You asked if there is sharing. There is, as you know, a lot of sharing but this is not obvious and we sort of take it for granted. You probably know as much about it as I do. In the hospitals in Metropolitan Toronto, for example, and similarly in hospitals outside of Metropolitan Toronto, what is really common now is group contracting—central laundries, a central referral lab that's set up and operating. We have in Metropolitan Toronto central biomedical engineering, a small set-up of people who can supply the service in that area.

**Mr. Pope:** How about purchasing and accounting services? Are they centralized?

**Mr. McCarthy:** Centralized purchasing is very large and very successful for hospitals in Ontario. It started with the hospitals in Toronto and the Ontario Hospital Association then picked up the program and extended it to make it available to hospitals throughout Ontario. It's very successful. A few years ago I was the chairman of Hospital Purchasing Incorporated in Metropolitan Toronto, and I think our volume of business at that time was something like \$30 million, but there is a large number of hospitals sharing this.

**Mr. Pope:** Are you currently involved in any studies for any further sharing of programs or facilities?

**Mr. McCarthy:** Yes, we are. We don't want to hold out a great deal of hope, but we are. One of the things that bothers us, quite frankly, is the necessity of running an emergency department around the clock. You have it there whether it's used or not. It's like a firehall. If you have it, you have to staff it.

We have talked and are talking to Scarborough Centenary about this—the third hospital in our area is a chronic and rehabilitation hospital and doesn't have some of these programs, it doesn't have an emergency de-



partment, for example. We have wondered whether we could share our emergency on some kind of a rotating basis in the hours, say, from 11 o'clock until seven in the morning or something.

I don't want to encourage you to believe that that will produce very great savings or that it's a very ideal thing. We can't see that it's ideal. It might provide some savings if it could be worked.

Some of the difficulties of working it are, for example, how do you tell patients, "This week don't go to that hospital if you are an emergency case, go to some other one"? We think the problems and the risks involved in that might be kind of high, but we haven't got it working.

We have a very large emergency department, one of the largest in Canada. Our neighbouring hospital in Scarborough also has a very large emergency department. That volume cannot be handled in any one institution. You can't just say, "Well, one hospital is going to do without an emergency." This wouldn't work. It couldn't be managed during a large part of the day. It might be managed in the softer hours of the night, but we are not sure even of that. We are trying to get a handle on this but we haven't got very far on it.

**Mr. Pope:** Are there any other services you are looking at?

**Mr. McCarthy:** I wouldn't want to mislead you—we haven't done this in Metropolitan Toronto—but one of the things that's being done in a few places, and I noted your committee may be visiting Ottawa; they have introduced a central commissary type operation. They have one operating at Henderson in the Hamilton area. That would be something that could be looked at by our hospitals in Toronto.

The capital expenditure required to do anything on that is considerable. I mentioned that under the present circumstances we don't have resources to plough into seed money to develop that kind of thing—no one hospital has. And in my opinion very few hospitals right now could even contribute seed money to such a venture. But it is working in Hamilton; successfully I understand. It has been started in Ottawa. It is something that can be looked at, but we would have to have a lot of ministry help, a lot of separate help, to fund or look at such a thing.

**Mr. Pope:** If I could go back to something just for a second. You talked about your day-surgery program.

**Mr. McCarthy:** Yes.

**Mr. Pope:** Are there any other steps that you are taking to reduce dependency on active-treatment, inpatient care other than that program?

**Mr. McCarthy:** There would be very few patients admitted to our hospital, such as emergency patients, who didn't require admission, who should be sent away. I can't believe there are very many. Occasionally, there's been a judgement of illness that after a few days is not proven, and the patient basically could be discharged. But by and large, the patients are not admitted unless they really need admission. Then the next question is, are they kept longer than they need to be kept? Again, as the pressure on the beds is heavy I don't think there are a lot of patients in the hospital—and I can only speak for ourselves; maybe it's applicable to the other hospital in our area—there are not a lot of patients admitted to hospital and kept longer than absolutely necessary. Probably as members of the Legislature you receive complaints from people who think they were discharged too soon. We certainly get that, but not a lot of complaints. However, it is a concern that someone could be discharged too early, and perhaps encounter difficulty and through some unfortunate circumstances not get back to hospital in time to be treated. There have been a few cases in the papers about that. None of us like to think that could happen. But it could happen, under pressure to get people out quickly.

So to summarize, the people who are in hospital are there because they need to be there. Again I am generalizing, but I think people are kept no longer than would be absolutely necessary in our present state. If any are kept longer than is necessary, it is often because they can't be placed. There isn't an alternative facility to an active bed to put them in.

For example, nearly every hospital has a proportion of patients—it's been said 10 per cent—who, if they can't go to their homes for some reason have to go to an alternative facility. That alternative facility could be a nursing home. It could be a chronic-care unit. It could be a rehabilitation centre and so on. The home-care program in Metropolitan Toronto does enable a lot of patients to go out and be cared for at home after they can be safely discharged from hospital.

[4:45]

This is the dimension of the alternatives the minister is, I think, trying very energetically to develop. My own feeling is that our hospital in its present state can't do very

much about the lack of those facilities outside the hospital at present.

The mental health program is a good example. We have a very small psychiatric unit, but we have a very large number of patients. The only reason that the number of beds in our hospital serves the population is because there is a very large outpatient day-care program. Some patients can be discharged and go home, and return for physiotherapy, occupational therapy and so on.

The thing is a kind of continuum. I don't believe there is very much more that can be done within the hospital. There are alternatives that could be put in place outside of the hospital, but I don't believe the hospitals can put them in place themselves. They will have to have some support.

**Mr. Pope:** You mean community programs?

**Mr. McCarthy:** Yes. A day-care centre for older people is advocated. I think such a program would be desirable in our area. We have neither facilities to accommodate such a program within our grounds nor money to operate such a program. There would have to be funding, either siphoned off existing expenditures or allocated, to provide for such a program. It's like the chicken and the egg situation, it seems to me. Which comes first?

My feeling is that when you are down to the level of beds existing in our area, our present expectation—yours and mine as citizens—is that we would not be very tolerant of the inability to get what we think is necessary admission to the hospital. This often isn't the patient's judgement; it seldom is. But if patients are sent home when they feel they should be admitted, they are going to be complaining to us and to you people. Some of them are doing that.

**Mr. Pope:** Just one last question. You talked about a 10 per cent placement factor in your hospital. In the light of that, what is your feeling about this policy of conversion of active-treatment beds to chronic or rehab beds, and perhaps a reduction in the number of active-treatment beds, if we are looking at that 10 per cent placement problem you just mentioned?

**Mr. McCarthy:** Where there is a surplus of active-treatment beds, they could accommodate a long-term care program. There is no such surplus in our area, I can assure you. We do have a chronic long-term care wing, and one of the other hospitals is primarily all long-term care. The judgement there would have to be, what is the situation and what exactly is going on in that situation? I couldn't comment on what it is like in some centre where the bed ratio may appear

higher. Since I don't have all the facts, I wouldn't want to comment. I suspect the ministry could get the facts and could make a judgement on that.

**Mr. R. F. Johnston:** I am the new member, by the way, for Scarborough West.

**Mr. McCarthy:** Congratulations.

**Mr. R. F. Johnston:** I have specific interest in Scarborough General. Yesterday we had Etobicoke General here. They seemed to be presenting their case with a bit more sense of urgency to it, although in this whole funding process they tried hard to link the boroughs as being in general the losers in being tied into a Metro bed ratio because they are all using their beds to a higher degree than the inner city hospitals.

There are a few things I want to find out. Where does the catchment area for the two hospitals out there, start and where does it end in geographical terms?

**Mr. McCarthy:** The study that is going to surface here shortly will give really authentic data on that. The geographic boundaries of Scarborough are pretty much the geographic boundaries of our hospital, with allowance for the fact that some percentage of patients comes to us from the north and east. I think a slightly larger percentage of patients comes from the north and east to Scarborough Centenary Hospital which is closer to the northern boundary.

A fair number of patients in the chronic and rehabilitation beds were originally not residents of Scarborough. If you just fudged the edge of the boundaries of Scarborough a bit and put your hand on that area, that would be roughly it. As I am sure you know, there is no restriction on where you and I can go to hospital. There isn't any way the hospital or, I am sure, the government could say you are restricted in being admitted there. At present anyway, we have not defined a user restriction. Therefore, the provider of service really can't define it either.

**Mr. R. F. Johnston:** The referring doctors are primarily in the Scarborough area?

**Mr. McCarthy:** Yes, I would say that all of our active treatment physicians or virtually all of them have their practice in the Scarborough area primarily. A few of them have offices in the downtown core as well.

**Mr. R. F. Johnston:** Following from that, how many of them have rights at both Scarborough hospitals and how many of them have admission privileges at other hospitals?

**Mr. McCarthy:** Some of our physicians in the sub-specialties, for instance, ophthalmology, can manage to have two offices; that



is, they can be serving an area downtown and one in Scarborough. They could be admitting patients downtown as well as in Scarborough.

With that exception, most of our physicians, if they have courtesy privileges, are not exercising them. It isn't that they couldn't have them, it's the reality of practice. The day of the itinerant surgeon is over. He really can't practise that way. He couldn't possibly be flitting around from one place to another. The reality of practice now almost requires that a person confine his or her practice to one hospital.

**Mr. R. F. Johnston:** That jibes very much with what the Etobicoke people were saying yesterday. They were saying that there was a fair amount of pressure on their beds. I'll go into their percentages and we can talk about that in a minute. When it came to elective surgery, as an example, they felt it was more likely in their situation that the doctor who was linked to their hospital would keep that person on the waiting list of his hospital, rather than trying to speed up the process of going to another hospital. Would you agree with that?

**Mr. McCarthy:** Very much so. To take surgery—and it's not by any means that it's more important—the bed or the admission of the patient is really only part of the problem of scheduling; there is also the operating room time. There isn't any use in having a patient electively admitted to hospital for surgery unless the particular surgeon has some time coming up—unless that patient is an emergency, then time is made available. There's got to be an integration of the operating room time with the bed admissions. Unless it was an emergency, it just wouldn't be practical for them to have a patient here and here and here. I don't think it could be worked.

**Mr. R. F. Johnston:** One of the things they fouled up on that had to do with the present pressure on their waiting lists. I asked whether or not they thought doctors at this point were trying to increase the emergency factor in some of their patients in order to speed up the process. In their case they were; if it isn't happening at the moment with yourselves because of pressure perhaps not being as great, do you see that as a potential?

**Mr. McCarthy:** I would not like to suggest that there would be anything malicious in a patient. For some conditions, a patient could be held on an elective list; if their condition deteriorated and became more urgent, and if they couldn't be accommodated by a so-called elective admission, they

would end up coming to the emergency and having to be admitted.

**Mr. R. F. Johnston:** I guess what I'm leading up to is it seems to me that, as the pressure on waiting lists increases, so does the pressure on the doctor in making those kinds of decisions as to what the status of that individual is, especially if he is just dealing with the one hospital. The fact that there may be beds and surgery time available at Toronto General, or wherever downtown, is not a favour that can be taken into account by that doctor in Scarborough. He is going to be thinking about Scarborough General; he's going to be thinking about this patient with Scarborough General.

**Mr. McCarthy:** I think that's true. It wouldn't be possible for the surgeon—excepting in some subspecialties—to be trying to manage patients in several places, or even more than one. The surgeon's schedule is a daily one; he's either in his office, in the hospital or on duty in emergency. He can't be integrating all those things in several places. For one thing, it seems to me that if the hospital were to give privileges to someone, then it would expect something back for those privileges; one of the things is that you serve as a backup for the emergency department. You can't be in two places at once, unless again you're in a subspecialty where the incidence of call is remote, or something like that. You can't really be on call for two places at once—I think, anyway.

**Mr. R. F. Johnston:** The Etobicoke people yesterday raised questions of growth in their area, in terms of overall population and in terms of specific kinds of population as well. They were able to relate to us, for instance, that while they were having this very high occupancy rate—higher than the 82 per cent average you're talking about—they also knew of major housing developments being undertaken in their vicinity which they saw as just increasing the emergency level, if you will, for themselves. Is it likely that the growth we seem to see in Scarborough at this point is going to affect your ability in the next few years to handle—let's leave it at that.

[5:00]

**Mr. McCarthy:** It's our view—history may prove us wrong—there is growth, as you know, in the northern part. There is growth beyond the border in Markham and area. We believe, given the necessary constraints you and I have to face as taxpayers and as members of our society, it would be more economical to get better mileage out of the existing facilities than to go putting up new bricks and mortar. How long could one sur-



vive in that mode? We don't know; we're just guessing that the necessity of building another active-treatment hospital in Scarborough could be postponed for five years. We think that but we could be wrong and we couldn't speak for somewhere else.

The Scarborough study is going to be addressing this question. As we point out, you are either fortunate or unfortunate to have access to a letter which we had sent to Mr. Cornwell expressing the same view to his committee.

**Mr. R. F. Johnston:** Just for myself, I know in my own riding, which is the established area of Scarborough, in the next year and a half we're expecting a growth of another 5,000 to 6,000 units in development along the subway line. I know that the density proposals for along the LRT are also very high and there's an awful lot of pressure. Even before LRT gets itself established, some of those buildings had better be in position or they're going to lose too much money on TTC, et cetera.

I'm just wondering if the study you have coming has taken into account that kind of development within the established area of Scarborough as well as the growth in the Malvern area, et cetera.

**Mr. McCarthy:** I would suggest that Mr. Cornwell could come here and speak to that. We made our presentation. We were a party to a lot of the information that went into the study, but I can't recall the borough. I am sure it was asked to identify what it believed to be the growth areas and the growth, and the consultants were using figures supplied to them in that regard. If those figures are wrong, and of course they could be out of whack, if the borough planning authorities have correctly identified what's happening, then I think the report should identify the problem and answer that question.

**Mr. R. F. Johnston:** On the occupancy rates you have, I am kind of surprised with all the growth that is going on out there that you don't have a higher occupancy rate in your paediatric area. Yesterday we learned that Etobicoke's was sometimes 140 per cent capacity. I forget what you said yours was. You said it was not too bad.

**Mr. McCarthy:** We are right in the centre of Scarborough and the area is not an absolutely new area. It's new by comparison with Elizabeth Street or somewhere, but it's not new and the age of the population has really gone beyond the paediatric age. The newer areas are to the north and this study was addressing that.

As far as we're concerned, the demand for paediatric beds is not excessive. I think there's been quite a change in terms of the practice by paediatricians in that regard. Given the same number of people 10 years ago, I think more paediatric patients would be admitted than there are today. I just sense that. You could call a paediatrician before you and ask him that question. Where there's new housing going up and new family formation with young families, that's the kind of area where for a period of time there would be a peak on paediatrics, and we're beyond that point.

**Mr. R. F. Johnston:** Even with the new catchment areas to the north?

**Mr. McCarthy:** Yes, we don't feel that that is a problem. We think we are quite capable of managing paediatrics. As a matter of fact, one of the concerns most of the hospitals like us have is that we have a surplus of beds that were called at one time paediatric. You can't put adults in cribs; if you have 50 cribs they are not much use if there aren't babies to put in them. But if you have an adult bed, what has happened is that the growth in adult patients in numbers and demand has simply occupied the reduction that was forthcoming from the reduction in paediatrics.

In our hospital, conversion is one of the things we have advocated, but some of these areas can't be managed as adult facilities without some modest physical change. However, we do feel that if necessary, and if the funds for capital conversion were available, we could convert to adult beds a small area that previously was devoted to paediatrics and is no longer occupied. But if you add beds you have to have the money to run them; you can't run them on water or air. You have to have the money to staff them. So we couldn't manage any additional beds now unless we had additional operating costs.

**Mr. R. F. Johnston:** That was my next question, coming out of that. I am not sure if you are aware of the situation at the Etobicoke hospital, but they told us yesterday they have about 100 beds around the hospital which are unfunded beds. They are vacant primarily because they don't have the dollars to handle them. Because they often go over the 100 per cent occupancy rate in a number of areas, they would then fill these beds with individuals—say, women in labour, that sort of thing—and then not receive money from it. They were eating into their own funds as a result of that. Has that kind of thing been happening at all with Scarborough General?

**Mr. McCarthy:** As you know, we estimated that if we continued as we were, we were

facing a deficit of—well, the difference between whatever inflation proves to be and 4.5 per cent. We estimated that to be \$650,000 for the current fiscal year. If we didn't trim our sails somehow, or augment our revenue somehow, we would be in a deficiency position, and we couldn't continue long with that size of deficiency.

It is not possible, on the other hand, to be absolutely on target all the time. Even in the fiscal year just finished we have ended up with an operating deficit of something like \$30,000. When your budget is at the \$28 million to \$30 million level, you are pretty lucky if you are that close.

I think that could happen under pressure. Since the front door of the hospital is open, namely the emergency department, and the patient comes in and requires treatment, you almost have to place him. We don't have control of demand. We struggle all the time to manage this; I am sure other hospitals do, too. I can't comment on the Etobicoke situation because I don't know it.

**Mr. R. F. Johnston:** But the \$650,000 you are talking about was the difference between inflation and your budget; it had nothing to do with using beds for which you were not receiving dollars specifically.

**Mr. McCarthy:** No, that \$650,000 was contemplating the same volume of patients. If more patients arrive, that deficit would increase.

**Mr. R. F. Johnston:** Okay. I also got the impression from the things you were saying it was not that you were considering your past practices to be inefficient by any means. When you start to talk about some of these means of raising money through parking lots and through phones, and looking to save money in other areas by amalgamating services, et cetera, you are not saying, I don't think, that what you were doing before was inefficient.

**Mr. McCarthy:** No. We would never claim we have achieved perfect efficiency, but we certainly have struggled for a long time to be as efficient as we knew how. This was simply another way of looking at the matter. Efficiency and effectiveness are two parallel but related things and the efficiency part of it is very difficult to know. When you're getting 20 miles to the gallon out of your car you know you're running it efficiently, but when you're operating at \$128.61, which was our gross operating cost per diem the question of efficiency is hard to answer. This table from the ministry book and those figures are included.

The question of whether that is efficient, or absolutely efficient, is hard to answer. When you consider that among the hospitals in our size group, or peer group if you will, the average was \$138 and our rate was \$128 we could say it would appear we're really more efficient than average. But you can't rest on your oars and say that; you keep on trying. Having reached that level of efficiency, we didn't think we could achieve \$650,000 more just by simple efficiency. We simply had to reduce some programs that cost money and increase some programs that raised money. That's really what we came to; efficiency wasn't going to meet this any longer.

**Mr. R. F. Johnston:** I admire your response. I think that's been the hospital's point of view, and that's a very positive thing to do. I also admire that you don't seem to, as it were, lash out at the Ministry of Health. It strikes me that when you've got a hospital which seems to be efficient in general terms it's unfair that it's being lumped into a bed ratio along with other hospitals. It seems to me this is just blatantly unfair. There is no reason why the suburbs should be tied to downtown Toronto, given the kinds of things we've talked about. You aren't getting increases at the same level as inflation and the other kinds of costs you're going to be coming across.

I admire the response you have made but I don't know why you aren't angrier with the ministry for not recognizing reality in terms of your actual costs. How long can you keep responding in this fashion to try to become more efficient to raise more money? What happens when next year they raise the telephone bill by another dollar? Is that what you should have to be doing? It seems to me you're proving yourselves as a relatively efficient hospital as it is.

**Mr. McCarthy:** Mr. Chairman, I can only speak personally. I am a taxpayer, as you are, too. After all, we are all part of this big thing. There is no doubt that our society has to trim its sails. We are a part of it. Our hospitals are costing society money even though they're providing services. A hospital doesn't generate any new wealth like a gold mine or something like that, so we're very conscious of this. We seek to do the best we can. We can't do someone else's job for them; we're not authorized; we haven't the ability or we haven't the opportunity, so we simply have to do the best we can, and we are doing that.

In answer to your question of how long we could keep going on, we don't know.



Our board of governors is concerned even now that we have been gradually eroding some of the things we've been proud to have and which at previous times we thought were pretty necessary. We're gradually eroding these things.

[5:15]

It's not a precipitate thing. We're not going at it precipitately, we're doing it as responsibly as we can. But our board of governors and certainly some of our people feel we're eroding a system and could reach a point in such erosion where it is the point of no return.

We don't think of it that way on a daily basis. We just keep on trying and maybe we can find some ways—and we hope to find even this year things we didn't know about last year—so we can be more efficient.

**Mr. R. F. Johnston:** I think any administrator has to do that. As I said, I admire the approach you're taking. It seems to me you're being very resourceful, but as hospitals come before us, we're coming across hospitals that have been trying to cut costs systematically, a lot of them before any pressure came from the ministry at all. On their own initiative, they have brought in or are bringing in their own consultants to give advice on how to make their operations more efficient and, at the same time that they've been doing this kind of thing—I think because of general guilt about being too affluent or whatever—they have been already acting extremely responsibly.

While that is true, the two things I mentioned in terms of the kinds of funding parameters affecting the borough hospitals are happening; you're getting wage settlements being agreed to that are higher than the percentage amounts of money you're receiving to cover those sort of things. I think that you're almost being too reasonable when you're in front of us as legislators, who have a chance, hopefully, to influence the minister. I agree that, in your day-to-day operation you should just be digging in and trying to make do, but when you're here I would hope that you would be willing to say that things aren't that good.

**Mr. McCarthy:** When I am speaking, I'm speaking as I feel; I'm not contriving to say something to you that I didn't believe.

**Mr. R. F. Johnston:** Oh, certainly not. I didn't mean to imply that.

**Mr. McCarthy:** If the government were capable, or anyone was capable of controlling demand on the hospital—the equation, as I see it, is the supply of service equals demand for service. The cost of supplying

service has to equal the demand, otherwise you're in a deficit position.

We have very little control over demand. The suppliers of service, and I speak of the hospital now, has very little control over the demand. I'm not sure that the Ministry of Health has much control over demand. The ministry has said that one of its objectives was to try to develop a greater consciousness of individual responsibility for health and for prevention of disease so that the demand would not be as great. At least, there would be no frivolous demand, no avoidable demand.

That's an admirable position and I think that's just great. I don't know how it's going to be done and I don't know how effective it's going to be. In the Legislature, you face the question of "is this to be a fully financed system or not?" I think that demands on the health service system could outdistance the ability of government to pay for that system.

Perhaps you could put it in this context. If I could go down to General Motors and demand a new car every year, even a modest car, I could probably increase General Motors demand by quite a percentage. That is I and my colleagues, my compatriots. But, if I were paying for that myself then I would have to exercise some judgement as to whether I get a new car every year, which is what happens in fact. But, in the hospital field when I want health or hospital care I just go to a hospital. If the doctor says I should be in hospital, I go. There is no necessity for me to do so, even if I had the ability to influence that situation.

I feel that this is a bit of a conundrum, the answer to which I don't know, for sure.

**Mr. R. F. Johnston:** But if you want to draw a parallel with industry, that's great. Almost all of them work at a profit, which of course you don't have to do either, in terms of trying to generate more funds than you need. But I don't know what company isn't taking inflation into account in the prices they're charging for their product. I don't know any of them that are trying to produce cars at less than the wage settlements they are putting forward. I would just say that the hospitals, in my view, have shown admirable response to the restraints that are necessary. I think that even before the situation was precipitated by ministry decisions, they were already acting responsibly in that area.

I won't belabour this point too much longer, but I see you being victimized by the overall restraint program. If in fact preventive care measures that made up for all the pressures on the various hospitals were



being put into place immediately. I would have no problems with that at all, but that is not the case. Preventive measures are being undertaken. Those are laudable and wonderful. But hospitals, and particularly the suburban ones we've been hearing from, and a few of the rural ones, are being hit very hard at this point in handling acute care.

It's not an either/or situation. It certainly shouldn't be. I just want to go on record as saying that what you're doing is great and admirable, but I see you getting caught in a bind which is not of your own doing.

**Mr. McCarthy:** Mr. Chairman, there's no doubt that the providers of service are the ham in the sandwich. We can't charge for our services; we are regulated in certain things; and we simply have to do the best we can.

Ultimately what will happen, if there isn't enough money to be spent on any particular project, or service, is that the quantity of that service could be reduced. I said we have a bit of a problem there, because when you have an emergency department you're really kind of stuck. The patients don't tell you they're going to come. They don't make a booking as they do on Air Canada; they just arrive. So you're stuck with that, as long as the door is open. I don't know what the solution to that problem is.

The next thing is the quality. If you insist on coping with unregulated volume, and you haven't sufficient resources, the quality would eventually suffer. We don't like to think about that. We feel that the quality of care has not been seriously diminished. We've had to cut out some of the niceties of the hospital, some of the things that have made the place what it is. But we don't think that our quality has eroded too badly at this point. If it continues, we can't comment. We'll have to see what happens.

**Mr. Acting Chairman:** Thank you very much. It took a long time. Mr. Conway, you have the floor.

**Mr. Conway:** I really enjoyed both Mr. Pope and Mr. Johnston's questions, because they did anticipate many of the things I wanted to discuss. I particularly enjoyed listening to the last exchange between Mr. McCarthy and Mr. Johnston. For anyone who sat on the select committee on health care costs and financing, this sort of dialogue is very reminiscent.

I just want to say, very briefly, I really appreciate your coming here today. Unfortunately I wasn't here yesterday when the Etobicoke people arrived, but one of the concerns that many members on this committee have, privately if not publicly, is that each of us, and particularly those of us who have

responsibilities in the health field directly, have in our own way been very impressed by the fact that a great amount of public and private concern has been evinced by administrative people at the hospital level, by the medical and associated professional groups within the health-care industry, by the general public and boards of health. When the politicians are, in a legislative capacity, trying to quantify or be more direct and specific about the impact of certain government policy which we in the opposition feel is inappropriate, it is unfortunate I think, from my point of view at least, to see people who have complained in some cases so vigorously so reluctant to come forward for whatever good and predictable reason there may be. I wanted to say that I think your presentation, both oral and written here today, has been helpful.

I gathered the Etobicoke presentation yesterday was also very useful and very helpful. If I had one general comment, it would be that the tone of your presentation here today is such that you feel that under present conditions the problems facing Scarborough General are in ways difficult, but manageable, but as you look at the immediate future, if current trends continue, the quality of care, which you've dealt with in your recent exchange with Mr. Johnston and which you indicate has not suffered substantially in the recent past, could deteriorate over the next two or three years. Is that fair?

**Mr. McCarthy:** That's fair, yes.

**Mr. Conway:** Well, you've covered most of my points in earlier questions. I just want to thank you for being one of the more forward and, I suppose to that degree, heroic of the hospitals in coming before us.

**Mr. McCarthy:** It's a privilege, Mr. Chairman.

**Mr. Acting Chairman:** Are there any further questions from any member of the committee? Thank you very much, gentlemen, for appearing before us. It seems to me you only have one problem; how to face that \$650,000 deficit. You seem to be approaching it very positively anyway. Thank you. You've been very helpful to the committee.

**Mr. McClellan:** Just before we adjourn, Mr. Chairman, the committee was promised a bed-need study that was done for the district health councils.

**Mr. R. F. Johnston:** Oh, yes. I don't know if it's been looked at.

**Mr. Boddington:** It should be forthcoming, I hope. I put the request again yesterday. If we don't have it tomorrow, it will certainly be at the first of next week.

**Mr. Acting Chairman:** Well, perhaps you can report it if you don't have it tomorrow. Let us know for sure.

**Mr. Boddington:** Sure.

**Mr. Acting Chairman:** Thank you. It's been very easy. You've been good boys today.

Meet tomorrow at two o'clock.

**An hon. member:** The steering committee at one o'clock.

**Mr. Acting Chairman:** That's right, the steering committee at one o'clock.

The committee adjourned at 5:28 p.m.

## **SPEAKERS IN THIS ISSUE**

---

Blundy, P. (Sarnia L)

Breaugh, M. (Oshawa NDP)

Conway, S. (Renfrew North L)

Johnston, R. F. (Scarborough West NDP)

Kennedy, R. D. (Mississauga South PC)

McClellan, R. (Bellwoods NDP)

Pope, A. (Cochrane South PC)

Rowe, R. D.; Acting Chairman (Northumberland PC)

Warner, D. (Scarborough-Ellesmere NDP)

**From the Ministry of Health:**

Boddington, G., Executive Officer, Minister's Office

**From Scarborough General Hospital:**

Greve, A. J., Assistant Administrator

McCarthy, B., Administrator



Ontario

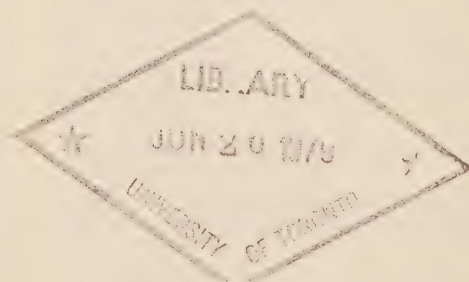
No. S-23

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Wednesday, June 6, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

WEDNESDAY, JUNE 6, 1979

The committee met at 2:13 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

**Mr. Chairman:** Before we call our witnesses for this afternoon—Mr. Wetherill is here, and Mr. Martin Sarra, I believe—as you know, the committee is going to visit four places next Wednesday, June 13: Ottawa, Windsor, Thunder Bay and Sudbury. We want to be apprised of the members who are going to each location. It is felt that there should be a member from each party; so I would appreciate it, for the purposes of cleaning up this matter in terms of making arrangements, getting airplane tickets where appropriate and so on, if we could have the names of the people from each party who intend to go to each location.

First of all, Ottawa: I believe Mr. Conway is going to Ottawa, as are Ms. Gigantes and Mr. Kennedy.

**Clerk of the Committee:** Is Mr. Kennedy still going? He said he would go someplace else if we needed him.

**Mr. R. F. Johnston:** Is that a suggestion? [2:15]

**Clerk of the Committee:** So who have we got now? We've got Sean and Mr. Kennedy—

**Mr. Chairman:** And Ms. Gigantes.

**Clerk of the Committee:** —and Ms. Gigantes. Now we need—and if anyone else wants to go, we can put four on there. Let's get the—

**Mr. Chairman:** The Windsor one would be—

**Clerk of the Committee:** Mike Breagh, Dave Cooke, and Bernie Newman; I need somebody from the PC caucus.

**Mr. Breagh:** I don't understand why there is a Tory willing to go to Windsor these days. I can't figure it out.

**Mr. Turner:** I just came back.

**Mr. Breagh:** That's what I mean.

**Clerk of the Committee:** Do you know Thunder Bay well? Fairly well?

**Mr. Pope:** Yes. Well enough to lose these guys in it.

**Clerk of the Committee:** Where could we book in?

**Mr. Pope:** Red Oak.

**Clerk of the Committee:** But that's not very good to have people in if we want to have a meeting room. That's a little way out. That's the one near the airport; am I right?

**Mr. Turner:** There's one right at the airport.

**Clerk of the Committee:** But what are you going to do with people coming in? They're not going to want to travel that distance, I don't think. You'll have to be closer to the centre of the city.

**Mr. Pope:** That's where a lot of people go.

**Clerk of the Committee:** Do they?

**Mr. Pope:** A lot of people go there, yes.

**Clerk of the Committee:** Red Oak, then?

**Mr. Pope:** Yes.

**Clerk of the Committee:** Okay.

**Mr. Chairman:** First of all, could you notify the clerk of someone from the Conservative Party who is prepared to go to Windsor? If we could have that this afternoon, it would be helpful.

**Mr. Pope:** Yesterday there was an indication that Windsor didn't want us.

**Clerk of the Committee:** But it was decided at the steering committee meeting that we'd—

**Mr. Chairman:** The steering committee felt that we should go down in any event.

**Mr. Turner:** And aggravate them.

**Mr. Chairman:** If they don't want to talk to us, then they don't want to talk to us. But at least we'll be there.

**Mr. Conway:** We should indicate that the steering committee did decide this afternoon that we would go to the four regional centres as had been previously planned. We would deal with the people who accepted the invitation to come, we would advertise in the regional press that we would be there for public hearings, and anyone wishing to make a written or oral presentation would be welcome.

Mr. Chairman: Now, Thunder Bay.

Clerk of the Committee: Thunder Bay? I haven't anybody. But I thought that maybe Mr. Pope—

Mr. McClellan: I'm going to Thunder Bay.

Mr. Pope: He always comes with me. What's going on here?

Mr. Turner: I need a hand.

Mr. Pope: Whenever I speak, you follow. Why don't we go together?

Mr. R. F. Johnston: I'm not sure; there's a quarantine on.

Mr. Chairman: Mr. Pope is going to Thunder Bay. Who is going for the Liberals?

Clerk of the Committee: Mr. Sweeney, I think you are committed for that day. Have you got anybody—

Interjection.

Clerk of the Committee: Mr. Sweeney has to be replaced.

Mr. Chairman: Perhaps later this afternoon we could have someone fill that.

Mr. Conway: Would Elmer Sopha—no that wouldn't do.

Clerk of the Committee: And Mr. Rowe has to be replaced, as I recall. He said he couldn't go, either.

Mr. Breaugh: Mr. Chairman, we should also tell the committee that the steering committee's recommendation is to hear the re-referral of the Lakeshore matter on Tuesday afternoon, after question period.

Mr. Conway: At which time we'll have the ministry's operational plan of transfer before us.

Mr. Breaugh: Maybe. We've had two versions of that so far, and it's early in the afternoon. Later in the day that might become a classified document; you never know.

Mr. Pope: Bring your own experts.

Mr. McClellan: First they have to write it.

Mr. Breaugh: The crayon broke.

Mr. Chairman: Yes, those two points should be kept in mind—I appreciate Mr. Conway and Mr. Breaugh mentioning that—as a result of the steering committee's meeting.

All right, for Sudbury: Myself, Mr. Wildman, and Mr. Ramsay.

Mr. Breaugh: We have a couple of members in the Sudbury basin in case you need beefing up.

Mr. Chairman: Okay. Are we all set?

Clerk of the Committee: We'll have to find out if—

Mr. Chairman: Mr. Conway, as chairman of the steering committee, is there anything further you wish to report concerning the meeting held at one o'clock today?

Mr. Conway: Mr. Chairman, I think you have encouraged all that was said and agreed upon. I don't know that there was anything other than the two points that have been mentioned. Unless someone else who was in attendance has something to suggest, I think the points have already been made.

Mr. Breaugh: I was going to suggest we offer our services to the resources development committee on a contract consultant basis. Maybe if we ripped them about \$4,000—

Interjections.

Mr. Chairman: Mr. Wetherill, would you kindly come forward?

I gather that you're the president of an organization known as EHE Ottawa Limited, is that correct?

Mr. Wetherill: That is correct.

Mr. Chairman: And EHE stands for?

Mr. Wetherill: Education, Health, Environment.

Mr. Chairman: All of which are very important, sir. I presume you'll be dealing with health matters today as they relate to your area, specifically to your company. Do you have an opening statement?

Mr. Wetherill: No, other than that I was asked to be here for a period of time. I can extend it until four.

Mr. Chairman: Are there any questions? Mr. Conway.

Mr. Conway: Could you give us a bit more on your background, sir, so we can appreciate how it is you are qualified or involved in the matters that are presently before this committee? The specific reference for this committee, as you are doubtless aware, concerns the active-treatment bed ratios, as the Ministry of Health has revised them, and the impact of those ratios on the provision of quality health care in the institutional sector in this province. Could you give us a bit of background on yourself and on your company as to the sorts of things you do and have done?

Mr. Wetherill: For about the last 12 or 13 years I've been personally involved in health care in about 10 or 15 countries. The projects I have tackled have dealt with the essentials of policy formulation and the functional requirements and operational management of health institutions and agencies, on an institutional basis as well as an area-wide or provincial basis, and on one or two plans which



have related to country-wide health-care services.

This has also involved not only health per se, but also education, the impact of environment upon health and education, and vice versa.

**Mr. Conway:** Could you perhaps indicate something about your own personal background and experience? Have you worked as a management consultant or were you more directly involved with the provision of health?

**Mr. Wetherill:** I have worked essentially as a management consultant.

**Mr. Pope:** Could I ask a supplementary? Were you retained by certain governments or have you been retained by hospitals themselves?

**Mr. Wetherill:** Could I answer that by saying that clients as such can be national or provincial governments, local governments, institutions, agencies and occasionally an individual. We have a wide range of clients.

**Mr. Kennedy:** Might I know who some of your clients are?

**Mr. Wetherill:** The Ontario Ministry of Health, the Canadian Red Cross, Sarnia General Hospital, Columbia University in New York City, Louvain University in Belgium.

**Mr. Kennedy:** A blue-ribbon list, if ever I heard one.

**Mr. Conway:** On the basis of that very ecumenical experience, could you indicate to us what your views as a management consultant are about the present state of the institutional sector of this province, with whose ministry you've had some direct experience? Could you give us a general comparative commentary on the state of Ontario's hospital sector as it relates to other jurisdictions with which you've had an involvement?

**Mr. Wetherill:** Do you mean comparative within the province, or between provinces, or countries?

**Mr. Conway:** I mean this provincial jurisdiction as it might compare with other non-Ontario jurisdictions, out-of-country perhaps, as well as national.

**Mr. Wetherill:** I shall be presenting a paper to the International Hospital Federation in Oslo the end of this month. The subject of that is cost containment and a policy of thriftiness.

What this has required myself and my colleagues to look into is what each province in Canada is doing individually, as well as collectively, to address some of the so-called problems in health care, with an emphasis on cost.

We have received from each of the provinces, from both the ministries of health or departments of health and the associations, information on the last two or three years of development and, in many cases, providing us with agendas and policy formulations by which they hope to progress with those plans.

In terms of other countries, before addressing those items specifically, some of my work has involved the USA. We have recently received information from Senator Kennedy's committee on the proposed legislation of Jimmy Carter, much of which is trying to come to grips with the amounts of money being spent on health care.

I have also information from Great Britain, which is my place of origination, on how they have tried to cope with health care issues. I also have available to me information from Scandinavia and central Europe and Australia.

In going through the general information there were some interesting findings in terms of Canada. As a personal belief, a province like Newfoundland stands more to gain from developing an aggressive program in health care than any other province in this country, the reason being it is relatively poor and has been somewhat behind in its development over time. It has not gone through that inevitable cycle of events which many of the provinces had and are now finding that some of the action they took some years ago maybe has to be critically reviewed.

Alberta, on the other hand, has wealth, as we all know. Yet, surprisingly, Alberta has a similar set of problems. With all this money it too is facing how it can provide health care at an affordable level of cost.

When looking at Alberta, where there have been some changes through the ministry structure moving from a commission to a department, they have been trying to come to grips with how much money should be provided to the health-care institutions, namely hospitals, to conduct their services in the future. There they have also attempted, and I am not sure whether this is yet fixed, to control operating budgets of hospitals. The last figure I remember was approximately eight per cent.

In New Brunswick, they have had a task force committee in operation for some time, a few years, and I believe that task force committee presented approximately 75 recommendations which, in my mind, were very progressive. They tackled not just the hospitals, but all aspects of health care. They tried to be comprehensive in examining the various requirements.

In Manitoba, the statement was made just recently—and I believe it to be unofficial but it can be repeated—that they had over the last four to five years progressively looked at cost containment in the health-care field and had found themselves getting to a point where they could go no further. They believed they had in fact eliminated a great deal of the fat in their system.

This is rather interesting, really, because when you look at what Manitoba has done in a few years, Ontario, which has been progressive over the last few years in addressing many of these health-care issues, has been doing similar things to what Manitoba has and without exception there is the control of budget. Control of hospital budget is something that is pretty well operative across the country, as you probably well know.

[2:30]

The approaches to doing this in the macro sense are about the same. It is the development of guidelines where possible, setting of limits, looking for alternatives in order to compensate or provide a level of service which many people are not receiving at this time.

To finalize on that statement with respect to Ontario and within Ontario, there are guidelines that have been looked at; the number of beds per thousand; looking at a guideline for controlling operational costs; looking at a way of being able to develop alternative-care programs, with the emphasis on looking for something that fits—in other words, a person receiving care which is appropriate or adequate to their needs, and I think without exception everybody involved in health care is having trouble identifying real needs.

This means that some of the approaches that are taken are “suck it and see,” and there is, again, no exception.

**Mr. Conway:** Would you repeat that? The approaches are . . . ?

**Mr. Wetherill:** Suck it and see. In other words, try it. In other cases, one can use experience from other countries and it doesn't always work out to be worthwhile.

**Mr. Conway:** I must remember that; suck it and see. It is the story of this committee's last six weeks.

I want to ask you a more general policy question, and that has to do with such statistical rules as active-treatment bed ratios. I remember sitting in a select committee here a year ago on health-care costs and financing. One of the management consultants or professorial types who appeared before us—we were talking at the time about proper doctor-patient ratios—this particular specialist indicated that

there really was no such thing, that it was at best an arbitrary and almost pointless or meaningless thing to talk about; notwithstanding the fact the World Health Organization had established some kind of figure which was supposed to be optimal, there really wasn't any meaningful figure in that connection.

Is there ever a meaningful or acceptable active-treatment bed ratio? In this province we have moved down from five to four and we are heading down now to 3.5 active-treatment beds per 1,000 population. What is your view, as a management consultant, of the appropriateness of that kind of guideline? Is it ever anything more than just a budgetary guideline that has very little to do with good health care planning?

**Mr. Wetherill:** I think it relates to budget as it relates to a number of things. Yes, the World Health Organization does have guidelines. I am sure you know various countries adopt these guidelines and modify them over time, depending upon how much money is available, people's attitude toward health care and social development and lifestyle. There is change taking place right across the world at this time in terms of guidelines.

Whether in fact these guidelines are appropriate or not, sometimes one has to question guidelines. I often come across people talking about guidelines as standards, and this might be a question of semantics and often is, but if it is a standard it becomes something very rigid, whereas a guideline should be applied somewhat flexibly. In other words, if you cut across the board with a guideline and say everybody is subjected to that guideline as a standard, then you stand the risk of some people coming out quite well and some being hurt. We are quite well aware that is happening, no matter where guidelines are produced.

From experience I believe Ontario's guidelines on the number of beds per thousand for active treatment are getting close to a very strong guideline if, as I believe them to be, they are serious in developing alternatives to the purely traditional status quo form of providing active care.

I have looked at a number of hospitals in the last six months. One of the surveys we do, which takes experience and judgement, not only on our part, but on the part of physicians, nursing staff and administration, is to take a one-day census of patients in the beds in that hospital on a given day. We often find that the number of patients who truly require active care in an inpatient bed is lower than is reflected in the guidelines of today in this province.



**Mr. Conway:** So on the basis of that evidence you are finding in many parts of this province that if such a guideline is at four or 3.5 it is not unreasonable, assuming the alternatives exist?

**Mr. Wetherill:** In many parts it is not unreasonable.

**Mr. Conway:** It is puzzling as far as I am concerned that we have not really developed a management technique for identifying and rewarding efficiency in the hospital sector. We have had some recent examples of that.

Could you share with us any personal views you might have, on the basis of your experience, which would help identify efficiency within the hospital sector? Could you suggest a policy and budgetary program that would reward the efficient and penalize the inefficient? Under present conditions it seems that all are treated similarly, since we can't identify either very effectively, at least in this province.

**Mr. Wetherill:** I can share this in general discussion terms. It is very difficult to look at efficiency and good management and to help people not only to manage day-to-day functions, but to plan. Most people are incapable of planning, which is dealing with the long-term future and asking a few simple questions like, "What if I did such and such?" It is a very simple process, but it is feared, because there are times when people believe they have committed themselves to something they may not be able to live with in the future.

In terms of incentive and disincentive, it is often bantered around that an incentive is positive. There are negative incentives in which you set a time limit and say, "If you do not do something by such and such a date, then you will be penalized for an amount of money, or change in service, or something." I read a paper a short while ago entitled Incentives versus Disincentives, and tried to understand at that time the policies that might be being developed in various provinces in Canada to assist administrators to look positively at their futures as health-care providers.

There have been certain positive incentives built into the system. Here in Ontario there was a bill—I can't remember the number—designed to help trustees and administrators of hospitals see where something needed replacing which required capital investment there would be cost-sharing; I think the hospitals and the ministry were each responsible for so much. Over a period of time there was a payback with a return on what was saved.

I think there are many examples where one can see that an administrator of a hospital has actually tried to run his hospital well. If he is subjected to the same guidelines as any other hospital, then he probably stands to lose.

This means that that administrator, if he is on the borderline of being a good administrator, may question whether he continues that practice. His board, on the other hand—and boards tend to be somewhat remote from real health-care issues—may turn around and very aggressively pursue a course of action which says, "Withdraw and you will be like the rest, dog eat dog." That is happening now, and I never see that changing. The circumstances will always change—fresh issues and people, being what they are, will continue to do that.

I think there are ways of introducing efficiency measures with positive incentives, with rewards. We are trying to work on this now. We have been practising health care, inpatient accommodation, active care; there are a number of patients in those active-care beds who really require other levels of care. More often than not, they do. We could say, "If you can find a way of doing this, we will make sure that your budget is covered in order to provide those other levels of care," and leave it at that. Many of the hospitals find themselves in a position where, apart from the resistance to change which they may get from many of their staff or their boards and the medical staff, which takes a lot of energy, there doesn't seem to be any real incentive for many to pursue a progressive course of action which more appropriately locates people within the health care system.

Now, having said that, we are not too sure yet at this time how this would happen. In industry we find that if a director of General Motors increases productivity in sales by 100 per cent, he is probably given a holiday on the Riviera for the next six weeks. I can't see that in health care.

If you take out that kind of incentive, it doesn't leave much. There are many who are opposed to any incentives in the health-care industry. They believe that health care is a right and that the kind of administering of health care we discussed is something that doesn't really need incentive, it just needs good management. I don't know whether that is answering exactly that question; it is a very difficult one to handle.

**Mr. Conway:** I appreciate that. I just wanted to follow with a supplementary and then a final point before going on to other members.



Do I detect from the last part of your last answer regarding the principle of incentives within a system that offers health care as a right, that the incentive and the right are mutually exclusive sometimes?

Mr. Wetherill: To some.

Mr. Conway: To you?

Mr. Wetherill: I think there are occasions where that might, in fact, become part of our thinking process when working on a specific project.

Mr. Conway: I want that just a little more clear. I sense a management consultant fogging the air around me, and I don't mean that in anything but a pleasant sort of way. We often hear in the political community that health care is and should be an absolute right, and particularly in a public-funded system such as we have developed. That is one statement. On the other hand, there is the now almost knee-jerk political response about the need for incentives within that system.

Your comment and the use of your words really triggered the thought in my mind that in some cases those two principles are contradictory and mutually exclusive. Do you feel you can have very many effective incentives in a system that offers itself, by and large, as one predicated on the principles of health care as a basic fundamental human right?

Mr. Wetherill: I would have to say no.

Mr. Conway: Just a final point: I would like you perhaps to be a little more prescriptive here than descriptive, if it is possible. I am thinking of our new Prime Minister asking for the totality of your specificity. What would you prescribe to policy-makers in this jurisdiction with respect to planning for the deinstitutionalization that seems to enjoy a wide degree of support among the political community? In other words, I think it is not unreasonable to suggest in a province like Ontario that we have a fair degree of support for what is generally known as deinstitutionalization. What I am asking you to prescribe more specifically are policy initiatives that should be undertaken to effect that kind of general goal.

[2:45]

Mr. Wetherill: I think I can best handle that by describing the basic process of a project. What should be done here is to understand the population in which a range of services are to be provided, of which health care is but one of the major services; understand what exists in that population at the given time it is studied. Independently of what exists, understand what might be re-

quired; and this is where we come into trouble.

There are very few guidelines which are applicable, up to date and which have evaluation as part of their mechanism, for understanding some of the directions we should be pursuing with respect to health-service needs in any province or country. We are only dealing there with the status quo; that is, what we have been accustomed to in the past so many years. At the same time as we are specifying those requirements, we should look not at deinstitutionalization, or de-emphasizing acute care, but at the positive side of that. We could say, "What are the other forms of care which can be provided?" and try to establish some basic guidelines in order to look at the system in a comprehensive way rather than tackling any one point.

That sounds pretty good, but it is somewhat theoretical. In fact, if one takes that systems approach, it means there is a great deal of guessing required. There is the lack of positive information, or information you can use sensibly to determine those base requirements. If you can possibly achieve that, and it is achievable to a certain extent, then you can make a comparison between what might be required relative to need and what exists relative to need; and determine the degrees of change between what we have in status quo terms and what we might have in the future.

This requires a great deal more emphasis on policy planning. I think while there is some policy—certainly this ministry in the last couple of years under Dennis Timbrell has made great strides in that area and I have been following that very carefully—it needs to go much further, as I am sure the minister and members of his department are aware.

Mr. Conway: If you were dictator of all Ontario and you had the capacity to determine a practical initiative that impacted on health-care policy in this province, is there a policy that is practical and available to you under present conditions that you would be interested in proceeding with? Quite apart from all the theoretical framework of management systems, et cetera, which are very useful and very timely, can you identify something that a group of short-sighted party politicians might consider for the jurisdiction over which they have some planning responsibility?

Mr. Wetherill: I'll have to answer briefly and say no.

Mr. Breaugh: I welcome the opportunity to put some questions to you. I acknowledge

you have worked for the ministry and that you do have some relationship, and I would imagine have some further aspirations of relationships as well—

**Mr. Pope:** Another lawyer.

**Mr. Breaugh:** No, I haven't got that kind of money. I do appreciate the chance to talk to someone who is considered by his peers to be in possession of some expertise and some experience in the field.

We have been looking both at statements of the minister before this committee and some very clear statements made by local hospital boards and local medical associations. There appear to be several different worlds in operation here. Policies as stated by the minister in his opening statement before the committee don't even seem to be known, let alone implemented, at the local level. There appears to be a constant problem there of, I suppose, communication, but in part it is certainly in planning, something that you centred in on.

If most of the hospital boards that have been here have consensus on one matter, it is that they do not know from one year to the next what the rules of the game will be. We have tried, in this committee, to find out something as simple as whether or not there will now be a 10-bed buffer in smaller hospitals for the remainder of this year and on into next year. There was some difficulty, I am not sure we got a clear answer on that.

It all points back to the rather simple concept that if you are to run something as complicated as the health system there is a need to have clearly identified goals and a plan of operation over more than a one-year period. That would appear to be a major flaw in what is now occurring. If there is an overall plan, the people responsible for administering hospitals don't know about it. Could you make some comments in that regard?

**Mr. Wetherill:** I can certainly make the comment that I agree there has to be a long-range plan which is more than a one-year by one-year action. Administrators and trustees need such a plan, and so does the ministry. I have been in this country since about 1969, so I can't go back too much beyond that, but I have tried to understand various provinces, and particularly Ontario.

I think there has been a progressive development towards developing a set of policies in terms of an overall provincial plan on the part of the ministry, certainly over the last two years. If I look very carefully at some of the statements that have been made by the ministry and I begin to piece them to-

gether, I begin to see the basics of an overall plan. I would not say there is an overall plan as such which everybody can handle in a very tangible way.

**Mr. Breaugh:** Aside from the rather unusual phenomenon of a group of people laying out about \$4 billion a year and not having a clearly defined plan related to why they are spending that kind of money, let me put to you the very simple problem that was put to the committee in the minister's opening statement. He had four major thrusts in health care in the foreseeable future. He laid those things out for the members of this committee in a very nicely typed, double-spaced and widely circulated statement.

That's very nice, except that about three days later we met a group of about 100 or so hospital administrators and they were not even aware in very general terms what the four major thrusts were; nor have we been able to get anyone to identify how the ministry hopes to accomplish those four major thrusts. How much of that is a communications problem and how much is it a very serious planning problem in the sense that we are still at the general principle stage with no real concept of how it will be implemented?

**Mr. Wetherill:** Communications is a two-way process: somebody says something and somebody listens. There is a lot being said and there is very little listening. I would like to repeat that: there is very little listening, even on the part of some of the better hospitals. In my terms, better hospitals are those that are well managed. They have fears, they are scared.

All over the world one finds that when ministries set out plans there are changes. Governments have four-year cycles. The first year is a startup, the middle two are all rush, and the last one is giving things away. That kind of process makes people very edgy. The ministry is trying to find ways of being able to demonstrate that change is necessary; which I fully support, it is necessary; but the speed of that change is awkward.

It could be said that the speed of this change has been a little too fast for most people in this province. I think that is true in some places and in some cases, particularly in those areas where they—"they" being the hospital and its community—have enjoyed certain benefits and freedom find now that there are policies and guidelines that are developed which may prevent them from doing what they have done well in the past—well in their terms because a number of them have not performed well.



The four main thrusts given by Dennis Timbrell have been there for some time. I think one of them is the formulation of district health councils to decentralize the actions on the part of ministry and the communities so the communities are more responsible for understanding and controlling their futures.

There are many places where district health councils are not understood. There are some where they may be understood but they are not liked. There are others where district health councils are liked and have done competent work. So already we have a range of talent, as such, in the decentralized system of district health councils.

The concept is good. How one actually engineers the mechanism for progressive planning, which includes not only management as to how those milestones become the reality of today but how one evaluates one's performance both in terms of how well you did and how poorly you did, is not enough real hard evaluation. There are too many statistics floating around which can prove too many things of the wrong kind.

**Mr. Breaugh:** One of the things on which again there appears to be a consensus, and which you just mentioned, is the inability of people to listen. I would say of the testimony before the committee that that listening process doesn't seem to work very well at the ministry itself either. Could you make some suggestions as to how that might be rectified?

**Mr. Wetherill:** I made that statement in a paper a while ago. Health-care providers must stand up and speak instead of being in the back corridors where sometimes it's not too easy to hear them. They must also listen.

The same goes for government. It, too, must listen. Its antenna sometimes is a little rusty. When it's trying to cover many areas and many issues within those, as you can well appreciate, it's sometimes difficult to be able to handle all of those. But again I have to make the statement that in the last year at least there has been a great effort on their part to listen and understand. I think that's positive, but there's plenty of room for expansion.

In the health-care field there has been listening. It goes in one-year cycles. After the budget has been announced there are moans and groans on the part of many. They then find ways of being able to get around it. Some are good at doing that; others are not. They muddle through in some cases and get toward the end of the year and suddenly realize they haven't got sufficient funds. That becomes another kind of arena between the ministry and the field; that is, "we need more

to do more, we need more to do what we've been doing."

One is questioning whether what they have been doing has been genuinely appropriate.

**Mr. Breaugh:** Could I move through some other rather specific points? There has been a great deal of discussion here about various formulas, guidelines and what not. Though they appear to be rather neat little pieces of business in theory, in practice there seems to be a great deal of dispute about them. For example, there doesn't seem to be much of a consensus on whether a bed ratio formula of four per thousand or 3.5 per thousand is realistic, applicable even, in all centres in all parts of this province.

In theory there was a nice neat package presented involving a reduction of the number of beds per thousand with two major zones, one in the north and one in the south. In practice that doesn't seem to be quite as neat as it originally seemed to be. Yet it appears, in my judgement anyway, that that has become much more than a guideline, flexible and open to some interpretation and allowing for local variances and allowing for local conditions; it is very close to becoming a very rigid standard and one will get funded to that particular formula and not above. Isn't that a dramatic misuse of a guideline?

**Mr. Wetherill:** If it becomes a standard without any tolerance or flexibility, yes, in anybody's terms. Some of our research at this time is into small hospitals. I, and colleagues of mine, believe that possibly a key to change in the health-care system is small hospitals. They have immense value. They are respected by their communities; they are small enough to deal with; they have complex issues. They are not to be underestimated. You cannot use the same guideline for a large Toronto hospital as you can for a small rural hospital. There was some attempt to recognize that.

[3:00]

As long as that remains a guideline and one then individually understands the specific requirements of each health-care institution within its community, and observes the guideline and the degrees of tolerance for each specific case; looking not only at acute-care but chronic-care programs, not just beds; looking at day care as a real thing in terms of not just sickness but well-being; understanding home care as not just being some nurse who decides she ought to go and help somebody when she feels like it, or within the bounds of the local health board; that is when one can be a little more specific and understand the unique requirements of each individual situation. That, to the best of my



knowledge, is now taking place. Projects that we have, from the ministry or from the district health council or an individual institution, now pursue that course of action; and I think that is being done in many other cases.

**Mr. Breaguh:** I wish it were. It's my distinct impression that it's not.

**Mr. Wetherill:** I think there are people who will say that, and I am sure that is happening in a few areas. It's bound to under anybody's guise. But I think the emphasis is in the positive direction I've just mentioned.

**Mr. Breaguh:** You talked about cost control, and you brought up a matter that has been put before us on more than one occasion. That is that we've come off about 11 years of global budgeting.

During that time period, hospitals which attempted to increase their cost efficiency to save money ran into the rather inglorious process of getting a kick in the head the following year because they didn't get to keep all of their savings, in some cases even part of their savings. In fact, they had the global budget reduced. Because they had been good boys and girls in the previous year they were penalized in succeeding years.

Many of the administrators I talked to have, to put it succinctly, been burned in recent history and are reluctant to be burned again. If they saw something that extended past this budget year, over the next three-, four- or five-year period, if they had that kind of assurance they might be prepared to go back with some more vigour and go through it again. But we had this conflict of global budgeting, and then an almost rigid formula system with some flexibility, it seems, for some people and not for others, and no real handle on future years ahead of them.

It strikes me that—let me put a hooker on the end of it—one of the things that ministry people have been saying, again and again is put in management consultants. The theory is that they will save hundreds of thousands of dollars, even in 73-bed hospitals. That hasn't been my experience, I'll tell you, with management consultants.

Out of all of this, it seems we've gone from one extreme to the other. Was there not a need for a transitional period, some assurances, some long-term planning, some guarantee of flexibility?

**Mr. Wetherill:** There is a need for long-term planning. Some of that is being done now.

Cost containment is an awkward pair of words, when put together. There are many administrators who have not efficiently oper-

ated their hospitals. Some of those administrators know it. They haven't necessarily had their guidelines in order to be able to do that. Others don't know it.

I know of management consultants who can go into a hospital and take out money. There have been large sums of money, I must admit, that have been suggested and, in a number of cases, I know this has happened. But cost containment is what I call a short-term solution. It is not a long-term solution. The objective should be active management of the institution so that each administrator doesn't need consultants, not to pave the way for consultants to keep helping them out, year by year, to chisel money out of the system.

In a discussion I had with the Minister of Health some while ago, he was very conscious of that. He realizes you have to start somewhere and I believe he's genuinely concerned that many administrators will look at it as a one-shot deal. He wishes to see them practise that cost-effective management for themselves, over time. The trick is, how do you actually develop the mechanism which is long term and not just short term?

While I'm delivering a paper on cost containment in Oslo, one of my statements is that I see that cost containment is short-term; it's interim. It can be related to a crisis situation if you like. I'm not suggesting it is the problem here, but it can be in the isolated cases of certain hospitals where they have been cost contained. I think a lot of the cost containment is not done in the way in which the ministry is presently looking at it, which says there are alternatives to place people in the system appropriately. That is absolutely true. It is very seldom practised in many areas, and there are examples where it is being practised and there will be more in the next year or so.

**Mr. Breaguh:** Let me give you an example of the kind of problem I have with what's currently being done. The minister in his opening statement, and several times in the House and in several other speeches, has alluded to something that's now almost become a fact because it's been alluded to so many times. There are all kinds of people in the wrong beds. There are chronic-care patients in active-care beds.

We attempted to determine what was the basis for that concept in a written answer to a written question. The minister replied that they couldn't provide us with the number of people who should have been in chronic-care beds and who were in active-care beds because you really had to do some kind of sampling. That had never been done.

We asked them to table with us their statistics on it, whatever they might be. In a writ-

ten answer they said no, they couldn't do it. This committee asked for those statistics at the beginning of its hearings. I understand that some of them have been presented to the committee today, though they have not been distributed yet.

In other words, there's no hard fact upon which to base the planning. Yet I see that Dr. Dyer, assistant deputy minister in charge of institutions, was before the committee and though he wrote the written answer that came back in reply to my question, saying it couldn't be done, on the first day of hearings here he not only said it could be done, he said they knew how many.

Now, my version of good planning is that you begin with knowing facts—you plan from there. Isn't there a serious problem with planning in the absence of any concrete facts?

Mr. Wetherill: Yes, and there's also a problem if you plan based just on pure facts, because those facts are statistics, and those statistics can be bent any way you wish, as you know.

Could I give you one example because I want to relate to this as a specific, if the committee has time? It will take a few minutes, but I can give you an example of what I did yesterday in a small hospital of 50 beds in the north. They have 50 rated beds, 10 of which are rated as chronic and 40 as active care. Of those 50 beds, as of yesterday, there were 33 patients occupying those beds—and remember we're moving into the summer period when it seems that people don't get sick for some reason—20 of those patients were female and 13 were male, eight were over the age of 65 and three were under the age of 16. All right, they're statistics; they don't tell you too much. They can tell you a little more if you look at some of the national guidelines, or even provincial guidelines with respect to the ageing population; look at the young, in terms of paediatrics and obstetrics, with an obvious relationship.

What we attempted to do was to sit down with the director of nursing, who's been there many, many years and has seen many patients. She's not a physician, but that does not mean to say she hasn't got a value judgement as to where patients could be located. I suggested to her that, as of that day, she had all of the alternative care services functioning well. If that were the case, where would those patients be located?

We reduced the number of inpatients, active care, to 15 out of 33. Two patients were truly chronic, so you have 10 beds there, rated and allocated, and only two

chronic-care patients needing to be in that institution. Two could easily go into a home for the aged, if it were available. Two could go into a nursing home, if it were available. Seven could be on home care, if the adequate services from VON homemaking and supplementary services and volunteers, as well as staff employed, were available to look after them. Three of them could be in a hostel, like a hotel, because all they were having were diagnostic work-ups and they were occupying an inpatient bed.

One of those patients was in there overnight because her physician, in his late 50s, as I understand, believes that a tonsillectomy should be in overnight. There are many, many examples of the simple procedure where that could be done on day-care surgery, so you eliminate a patient from any of that accommodation.

Three of those patients could be on day care. They are well enough to be at home, unsupervised, receiving at-home services, but would be required to come into the day-care centre two or three times a week over a period of four to five weeks. That is significant.

When I look at the population at that hospital, which is being set—and we are analysing that at the moment—set in terms of industry, how it is developing and so on, the 15 active-care patients come well below the present proposed guidelines. Now obviously tomorrow it might go up a bit, but that was on June 5, as an example, and there was no pussyfooting with that one. Later it was taught to the physicians, and the physicians in that community were quite reasonable in terms of saying, "Yes, if those alternatives are there, right. If they are not, no." I think anyone, including the Ministry of Health, realizes that if you don't have an alternative then obviously there's only one place for them to be.

Mr. Breaugh: That's obviously the nub of the problem. There isn't any shortage of that kind of analysis, but there certainly is the shortage. The term you kept using was "if available." All of us I am sure have visited hospitals throughout Ontario which could get rid of a large percentage of their inpatient population if other programs were available, if there was another place for them to go.

Mr. Wetherill: But in many cases those alternatives are available and are being made available.

Mr. Breaugh: Well, we would have some discussion about how many and in how many places.



**Mr. Wetherill:** You see, if you talk about isolated cases you can begin to see that in some cases they are available, but they are not being used efficiently. That sometimes may be the fault of the ministry. It may be the fault of the district health council. It may be the fault of the hospital or its board, the public health relationship within community services and even ComSoc, where there has to be greater communication in the ministries between the various departments, which I understand is taking place. In some cases it is working; people are taking advantage of it. But they need to take more advantage of it.

In the Cochrane district, there are three communities sitting on the edge of their chairs now, having become extremely involved in long term care-planning, prepared to seek more of the alternatives. In fact they are supporting the ministry in a careful way at this time to say, "We will proceed with caution to try to bring about more of what you have said in statements." I would like to add that if those three communities are receiving the information, what is it they have got going for them, which other communities who say they haven't received this information have going for them?

**Mr. Breagha:** Let me put to you what I think is a fundamental problem. We have the irony of a system of hospital care in a particular set-up which provides for virtually public funded private hospitals that have, as you have discussed often and at great length, supposedly a measure of local control with, in large measure, the financial controls assigned centrally. Isn't there more than one little conflict in the terms used, in the reality of saying that we have local hospital boards and district health councils which will allocate resources, control expenditures, design new programs, buy new hardware and all of that, except that they do not really have much control of the financial situation, the grant flow, the moneys that are made available?

**Mr. Wetherill:** My understanding of control, be it health care or any other service, is that he who has his hands on the pot of gold is in control. Okay, having made that statement, sheep need a shepherd but they also need the guidelines that we have been discussing, which are, in some fashion, gradually coming about. Some are being severely tested and others aren't. Hospital boards have more of a responsibility for health care and change than many of these hospital boards are willing to accept and understand.

[3:15]

I think hospitals should be in control of their own destiny, but working as teams and

not individuals. There are many examples where they have worked as individuals, and I can't say whether that's right or wrong. Each of us has our own little power trips and we wish to do our thing relative to others. In a system like health care, where there is a need to look carefully at the cost-effectiveness provision of health-care services, there has to be more co-operation. There are many hospitals such as North Bay that have been doing that, regardless of whether the ministry has said it should be done or not. There are other hospitals which I don't think will ever co-operate. I think that will be a fact of life for those communities.

Somewhere in the middle, there is this change taking place. If you ask the question, "Do you think that change is coming about through positive reaction or through fear of what might happen if they don't co-operate?" I can't answer, but I'm sure there's a bit of both. Some are willing because they see. Some are not, and they will oppose.

**Mr. Breagha:** There was a great deal of discussion about the machinery of modern medicine—I guess to pick the most obvious example, CAT scanners.

**Mr. Wetherill:** Right.

**Mr. Breagha:** There doesn't seem to me to be a clear consensus emerging in the medical community, let alone anywhere else, about whether that is an expensive toy—not necessary but nice to have—or whether it is a great medical break-through and a mechanical marvel that does great things for medical care and cost in general.

We're also in the middle of a controversy about the use of X-rays in general, and whether they are badly misused, used well, or whether they are good from a cost point of view, or whether they are good, in fact from a health-care point of view as well. Would it benefit any of us to get a source which says, "Yes, this is a good machine to have," and, "Yes, the cost benefits of using this machine, whatever they might be, outweigh any initial expenditures you might have"? In that way, you in the first instance get not quite an approval body, but a central opinion put forward that something is worth doing or some machine is worth buying.

In many hospitals I'm aware of, I see local boards listening to the local doctors saying; "Buy this." It's complicated now, because in many areas there are health councils saying, "Well, you as a local hospital board might think that's a great machine to have, but we don't." There appears to be no appeal body even. There isn't any place to go. You're just left with the argument. Is there anything



we could do that would at least alleviate that problem?

**Mr. Wetherill:** I think you've said, for example, that one needs to evaluate some of this high technology that's being introduced. This must be done in some fashion. I don't know of any concrete formulated body that actually makes those estimations with all of the expertise available to it. I think if it isn't available, it should be.

We're talking again about evaluation, which tends to be sadly lacking in many of the things any of us put together. Evaluation is something that's related to the future.

A CAT scanner to many board people is a thing that costs half a million dollars or thereabouts, costs a heck of a lot of money to operate and if it is big and it sounds good, then they must have it. You are right. That happens. There are many physicians who push that, because that is status.

Many new physicians, the young ones coming through medical school, look at the physicians of the past era, and say, "You know, these days to practise medicine you've got to be more than skilful in medicine, you have to be a lawyer, because I'm facing a malpractice suit, so I've got to have the best kind of equipment." This is said by whoever's selling and says it the loudest. It's on the market. To do the best job, the best form of equipment is no substitute for the mind, in terms of that first diagnosis.

If you want to whip to the other end, where you have small hospitals, physicians practising in rural areas, in some cases they haven't got sufficient of the diagnostic equipment to allow them to make a speedy diagnosis, which means certain patients are kept in hospital beds for longer than they need be. There we relate back to the bed factor again. And if you take it further and look at the technocrats whose big thing is to develop expensive equipment and make hard dollars in return, versus the medical community which looks at malpractice suits and looks at the Ministry of Health and any other relating ministry which is watching its purse as well as looking for appropriate forms of health care, you've quite a quagmire of activity. Something in there needs to be clearer than it is now.

**Mr. Breagh:** Do you think it's possible to make a kind of a clinical model of the level of service that ought to be available? In my visits to northern communities in particular, there were substantive problems not just in providing good health care but in attracting staff; and about what facilities the little local hospital had. I was told by

doctors and nurses and administrators that part of the problem was that if you couldn't put together enough machinery to provide a certain level of service, a certain number of beds, you couldn't get the people to operate the hospital. There was a level below which the whole place was virtually abandoned.

In effect, the ministry didn't close the little rural hospital. It simply squeezed its funds and that meant not enough machinery and that had a cyclical co-effect of not enough staff.

Could we design a model with all kinds of room for flexibility that said what makes a place a hospital? It has X-number of facilities, X-number of staff members—a great many things like that.

Is it possible to provide that kind of clinical model and then provide sufficient flexibility to apply that model on a local basis? Is it possible to say this is a primary care unit; it will have X-number of beds and there's flexibility as to how those beds might be designated?

In a number of the places I visited it didn't matter what the bed designation was. They were going to be used where there were needs and the only deal about bed designation was how you got funding. For all intents and purposes, in a number of the smaller hospitals I visited bed designation was a sham. It didn't have any direct relationship to provision of care at all or who was in the bed, and everybody admitted it.

**Mr. Wetherill:** That's true. There are a number of examples of that. Again, we're talking about management, we're talking about planning. We're not talking about how you can get through your first year or the one year you're dealing with, we're talking about way beyond that. Many of the facilities of small hospitals, for example, are very inefficient.

You talk to someone about planning and they immediately talk about physical planning, "You give me more bricks and mortar, and I'll do a better job." There are plenty of examples where that doesn't work, sometimes you do a worse job. But some of those facilities need to be altered and I think some of them are being altered, in terms of an overall plan and in the institutional part of this ministry, which looks at some of those facilities to see where there are some of those inefficiencies.

In terms of diagnostic X-ray, many radiologists and technical people will tell you, if they are not afraid to tell you, that there are many diagnoses that are being performed now that are not necessary. They cannot tell the physician how to practise medicine.

And it's not the technologist who's going to be on the line, when the lawyer says, "Here is a malpractice suit," which is a big thing, as you know. It is very much so in the United States, too.

There are pieces of equipment which are obsolete and depend on the local craftsman, the guy who looks after it. Some of them have been going for years and physicians have done a miraculous job with them. Cardiac work, for example; just the preliminary work-up.

There are so many of these kinds of things. If there were the time and the resources to look individually at every single health institution, identifying maybe a dozen factors, and developing what I call a generic base of measurement as a guideline, I think district health councils, private consultants or ministry, within the confines of an overall plan, could understand some of those idiosyncracies that exist now that prevent people from practising good medicine.

**Mr. Pope:** May I have a supplementary? Mr. Breagh was talking about the smaller hospitals. You have been doing some studies on Iroquois Falls, Matheson and Cochrane. Given the spectre of specialization and all of this monstrously expensive equipment, I am interested in professional contact, mobility to teaching hospitals, the desire of specialists and technically trained personnel, trained on more modern equipment, to locate where they can have access to people of equivalent training and equivalent education.

What would you say would be the priorities in ways to attract personnel? What kinds of basic equipment are now needed in the smaller communities? In a community with two doctors, where one doctor is leaving, what is the alternative to regional hospitals? In other words, what is the alternative you see, having looked at small hospitals, to the regionalization and centralization that is going on and the downward spiral of services through the referral population system?

**Mr. Wetherill:** First of all, I see that hospitals are going to change. They will be providing a greater range of service and will be involved with more than just the traditional forms of health care they have practised to date within their four walls. Many of the hospitals are now looking more to how they can be more involved with the community.

There are some physicians who have never practised that way and are not interested in practising any other way. They are not right or wrong. That just happens to be their belief. There are many new physicians who are interested in being involved more with what is outside in terms of pre-sickness, not just

sickness, and how they themselves can follow through and be involved in home visits.

In the Cochrane area and Smooth Rock Falls, for example, you have Dr. Andrew Hurtubise for whom I have a lot of respect. If you listen to him, and I'm sure you have, he'll say, "Give me some of the basics. I don't want all this high-powered stuff. Give me a little money to be up there and I can save a bit of the money you shove in here. I don't need it there, I need it up here." He is one of the people looking for that kind of change.

You cannot distribute expensive equipment to some of these small communities because their use of it is too small. Centralization of certain equipment is necessary, cost-wise and effectiveness-wise, because there are very few people who know how to use some of this equipment. We talk a lot about equipment but we don't talk about the specialists using it. I don't mean specialist physicians but the technicians and the nurses who also need to be there.

If one looks at a change in terms of positive dimensions, not cutbacks but positive in terms of growth, one will see a redistribution of funds in the health-care system which may call upon more funds for health care, but better distributed, providing much better, more appropriate care. I think that's the overall thrust. If somebody is asking about overall policy, maybe that's the policy that overrides all of this.

If you look at the pre-sickness requirements now, they are minimal in terms of screening people prior to their becoming sick, but they are growing. One may talk about de-emphasis there, simply because many people are in that situation, in an inpatient bed when they don't need to be. In terms of follow-up, there is more follow-up or post-sickness care than there is pre-sickness care. Then one has to consider wellness in terms of lifestyle.

Yesterday, again, at a hospital, the administration and members of the board agreed to allow staff, during two shifts, to develop a well-baby clinic. For the first time in that community, mothers with babies will be brought together to understand general things like feeding, which is nutrition. Without good understanding there, some of those kids might, in a couple of years' time, land up in that hospital for a physician to repair. Some of the physicians are keen that they can be involved to prevent that.

That kind of basic equipment is not a CAT scanner or an ultra-sound unit. It's basic equipment they have been taught to use—hands and mind, plus equipment. They want things like that and that means a shift of resources. That's where you need a plan, to



understand that shift before you make that change. But many people are reluctant to actually go that route, so I guess one has to pressure certain areas.

Does that answer that question? It's basic.

**Mr. Pope:** I understand what you are saying. I accept the division we are trying to make between pre-sickness and sickness, and I understand the priorities of public health and home-care programs and promoting wellness, but returning for a minute to sickness, where do you see the whole process heading in terms of what many people might call basic hospital facilities, basic hospital equipment and basic personnel required to use this equipment?

**Mr. Wetherill:** I see a continuation of what has been going on in the past number of years, not only in this country but elsewhere. The smaller hospitals will become what I have termed community health complexes, more encompassing. Any special forms of treatment will be referred to the bigger centres which attract that expertise.

If there isn't a theatre in a small community, and a physician likes to go to the theatre, it's surprising how many of them make the decision where to go ahead on the theatre. They'll go to a centre of excellence for the arts as well as medicine. That's a reality. So to try and distribute some of that excellence and the high-cost equipment doesn't make any sense. That means that people will be shipped to other communities, larger communities, where those services are available.

There was a model developed by the HEW group in the USA many years ago. I think a chap by the name of Rosenfeld put together a book which showed an overall concept of health care, in which there is a radial arm of a high metropolis population with a centre of excellence with all the specialists. He went into the smaller communities on the suburban periphery, which had small regional centres, not so much in the way of heavy stuff, although they had some of it; and to the small hospitals in the rural areas and the periphery areas which dealt with basic forms of care. I still believe that model to be applicable.

**Mr. O'Neil:** What do you refer to as basic care?

**Mr. Wetherill:** Basic care? Front-end primary service, physician contact, nursing. If I take the British example, there is the nurse practitioner, midwifery. You can add that into basic front-end requirements—people attention. I am not talking about neurosurgery in Smooth Rock Falls.

**Mr. Breaugh:** He isn't either.

Could I pursue a couple of things? I want to wrap up with these. It has been suggested that in a number of jurisdictions things are done in different ways by different people. The legal and educational requirements, the qualifications of who says that someone is fit to carry out a particular act, are somewhat different, to put it politely, from here in Ontario.

Is there a substantial cost saving that ought to be investigated in that field? Could the requirement for a pathologist in a lab be altered somewhat so that you could retain the guarantee of what kind of work is done, yet have the actual work done by other people? Administrators have suggested to me a number of things like that.

There is a requirement to send an RN with a patient over a long distance, yet the RN doesn't really do anything except that there is a requirement on the part of the administrator to provide that RN escort service. The nurse gets on a plane at time and a half and spends her day transferring a patient to another hospital. Administrators point out that could be done and good care provided without that requirement.

In that, in a number of other fields, could we have nurses accept much more legal responsibility than they do now? Could RNAs do a great many things? In other words, could we set up our medical care service—whether that's use of practitioners, or whatever—in a slightly different way, probably requiring stepping on certain toes in establishment forces? Would the value in doing that really turn out to be not much change in the level of care, but a substantial cost saving? Is it your view that can and should be done?

**Mr. Wetherill:** There is a great amount of room for that kind of change. There are still physicians who give you your shots for going into countries where you are likely to get yellow fever, when a nurse could give them. That's a very simple basic example. There is plenty of room for some of the RNs to do certain pieces of work which physicians still practise and for RNAs to do some of the work that RNs are given that responsibility for. I guess that's a pretty heavy area in which to bring about change too, and a lot of people will have their toes trodden on.

**Mr. Breaugh:** Yes, the flak and opposition would be immense from certain established quarters.

**Mr. Wetherill:** I am sure it would.

**Mr. Breaugh:** You'd have to be sure you were saving a substantial amount of money.



The other thing, obviously, is that you'd also have to be reasonably sure that the level of care would not drop substantively.

**Mr. Wetherill:** That is paramount. If one can maintain the level of care and see how far one can go, with the shift of responsibility—this I would not advocate on a mass move but if it were done in isolated areas to see what that can provide and what change there is in cost, up or down, I think it should be done.

**Mr. Breagh:** The final area I want to raise is—and you and a number of other people have raised it before the committee—this kind of funny relationship that has developed in health care in Ontario between the ministry and the people who provide and advise about health care. That relationship, in my mind, is unusual in many respects.

The Ontario Hospital Association, as an example, was before this committee and said quite bluntly it was their advice to their members not—I repeat, not—to make public complaints they had about the current budgeting process; they had always encouraged their members, if they had a problem, to go and see the minister. Which is quite a rational thing if you live in Metropolitan Toronto and you've three or four people who are good administrators on your staff. Or they're good with numbers, or if you are a friend of somebody in the ministry, so it won't be hard to get an appointment. You'll get a sympathetic ear; your staff can compete with their staff in the numbers war; it's quite practical. But it's not terribly practical for Smooth Rock Falls or Sensenbrenner, or Lady Minto, or hospitals like that to do it.

The overriding concern, whether we are talking about the hospital association or the medical association or the district health councils, is that this all seems to be done in-house. There is no opposition there.

As a matter of fact, as opposition members sitting on this committee, one of our immense frustrations is to try and get people to come here and say before a legislative committee what they are more than anxious to say over the telephone or when you are in their office. But, almost to a person, they say the same thing: "My God, I can't go and say that in public. I have to go back to the ministry next week and try to get more money. Now, I can lay my complaints before a committee of the Legislature this week, but you won't get me the cash I need next week to continue in operation for the year."

It strikes me that there is a severe flaw, and whether you call that an old-boy net-

work, or whether you try to do it politely, as I sometimes do, and say that a lot of this consultation is done in-house with the ministry, the fact remains a lot of public money is being spent and the public doesn't stand a snowball's chance in hell of finding out whether it's being spent wisely and well, or not well.

I can't say, because I am not a doctor, what somebody from the medical association in Meaford said—that next year there will be a serious hazard to health care in that area because of the funding problem. That was said by one of the few doctors in Ontario who is prepared to say it publicly. Most say, "Well, that might be true and I'll tell you that in a telephone conversation or in my office, but I am not prepared to say it publicly." It is that reluctance to have an open, honest discussion about what's right and what's wrong that compounds what might have been a simple problem initially into a very serious one afterwards.

I do not understand why a hospital association, of all people, supposedly representing its members, is reluctant to let its membership speak. That seems to me to be not a wise move. Now, it's certainly their decision to do that, but isn't that one of the problems we've got?

For example, even in my area not too many people in the public know that health councils exist, though there is one there. When I went to Kaplan and Cochrane and talked to people on the health councils there I asked them, "You've been in operation three years, what have you accomplished?" They said privately some things they wouldn't say publicly, but the gist of it was, "Well, if you ask us to point to something, we have it. If you ask us to point to a program that's in operation, it isn't there."

The same applies in almost every other area I've been in the province. People are saying, "Well, the health council might have raised the level of awareness among the professionals in the area, but in terms of co-ordinating services, in terms of developing new and more efficient programs, we really haven't been able to get to that yet." But the fact remains that all of this is done in-house behind closed doors. The opportunity to have an open, frank discussion about it is extremely limited.

I'm concerned that this committee will hear from the rebels in the profession, and no one else. I want the rebels to be heard, but I also want the others to be heard as well. Isn't that a severe problem?

For example, when the minister stands up and says that there is no problem in health care in Ontario—it stretches the credibility somewhat, particularly when a flip-flop is done a few days later. One day there isn't any problem with getting OHIP services at the opted in rate. That's a Tuesday. On Wednesday there's a cabinet meeting. On Thursday there's a need to announce a great new program between the hospital association, the medical association, and the ministry to provide those things that are opted out in rate.

You see, no measure of openness and honest discussion about this is even possible in Ontario. I am concerned that's a major flaw in the way we go about our business. Do you share any of those concerns?

**Mr. Wetherill:** I think I share the concerns the same as anybody does. From my brief encounters with the minister, if he were to say, "There are no problems in health care," then I don't know why he would waste his time in being Minister of Health.

I think he might be saying that there are certain problems that are raised as issues, which really aren't problems if people communicate. There are too many cases—and I come across this too—in first-time encounter with a board, when one of the things I will say is, "Do you have any questions of me before I begin this project? What are some of the things you wish to say?" It may be surprising to know that very few, if any, will ever come forth. They're more likely to send a communication through the old-boy network, or any other network that exists, to come through the back door to me to state their problem. But isn't that a people problem? I mean that doesn't matter whether it's energy, health, education or anything else that's going on.

**Mr. Breaugh:** Yes, you see—

**Mr. McClellan:** Do you think this area, more than in any other area—

**Mr. Breaugh:** You see, that's my problem. If this committee were dealing with trucking legislation, the truckers would be there, all of their organizations in place, everybody submitting written briefs. Next door, with landlord and tenant legislation, they are all out there laying it on the table. There is no shortage of people who are quite prepared to give both sides of the story.

In that kind of a process, a legislator like me can listen to both sides of an argument, assess the facts, and make a judgement. What I find particularly frustrating is that when you're sitting in their office behind closed doors, everyone opens up. But when you say,

"Would you kindly step in front of a legislative committee and say that?" Everyone—virtually everyone—says the same thing: "Oh no, I've got to go back to those guys next week". The OHA's official position is much the same.

How can we ever get a better health-care system, get some cost-benefit consensus working, when it's not allowed to happen in public? I mean, these are public funds being spent. The health-care system, I believe, doesn't sit in place out there; we don't spend \$4 billion to make doctors happy. We spend \$4 billion to make sure that the public is well served by a health-care system. Now, in my mind, that entails openness and some level of honesty, and that at least people aren't afraid to appear in public and make their statements. How many doctors in Ontario have been prepared to give even a casual comment about the effects of a restraint program on their hospital? Not many.

**Mr. Wetherill:** Have you ever attended an OHA annual meeting?

**Mr. Breaugh:** Yes.

**Mr. Wetherill:** And have you listened to how many people will challenge the minister on the platform?

**Mr. Breaugh:** Yes.

**Mr. Wetherill:** Have you ever taken note of the people who ask those questions? They are usually the same ones each year.

**Mr. Breaugh:** I didn't find that, no.

[3:45]

**Mr. Wetherill:** Well I found it, and I've attended quite a number. The present Minister of Health I think has opened up considerably. He made a presentation the other day in Ottawa at a region nine meeting of the OHA. There were administrators there I know very well who made a lot of comments afterward. They could have made them at the end of his presentation. Why didn't they? Are they afraid that if they put their foot out of line they're not going to get the budgets for next year? That would indicate to me that hospitals are being dealt with individually. They might put their foot out of line if they were being dealt with as a block.

**Mr. McClellan:** Let me give you an example.

**Mr. Acting Chairman:** I want to remind committee members that Mr. Wetherill has about 15 more minutes and I have Mr. Turner, Mr. McClellan and Mr. O'Neil on the list.

**Mr. McClellan:** This is an interesting, and I think an important, discussion. By way of illustration, we had the Etobicoke General Hospital before us at the beginning of the



week. As you know, that's a hospital that's been loud and vocal on the problems they're having about their deficit position, and about their bed situation and overcrowding. They were one of the few hospitals to come before the committee, and they made a very powerful case. In the middle of their presentation the government announced, through an interjection from one of the government members of the committee, that an isolation unit for which they had been negotiating with the Ministry of Health had been awarded to the Toronto General Hospital.

**Mr. Conway:** The joys of negotiation.

**Mr. McClellan:** Yes, the joys of negotiation. One wonders if there is an implication, an inference, communicated to me as a legislator, that the message is that is the punishment for speaking out. That speaking out is not the way you do business with the Ministry of Health in this province; if you want to do business with the ministry you better do it, as you said, in the corridors.

**Mr. Wetherill:** I don't think I said that you should do it that way. I said that's where it takes place.

**Mr. McClellan:** Yes, that's precisely what you said.

**Mr. Acting Chairman:** Mr. Breaugh?

**Mr. Conway:** Mugged by the mandarins.

**Mr. Breaugh:** I just want to finish with this last piece. I think it represents a fundamental problem we have in the system that's in place in Ontario, this absolute fear of people who believe that they have something to say and don't feel free to say it. I think if we've got one major flaw in health care it's precisely that.

The list of hospital boards which sent material to individual members of this committee indicated the problems they want discussed here. As a group we have been to those hospitals, and it strikes us their problems are not fictional, they are real. Now they have been invited to attend meetings of this committee and they are not coming. I believe there is a very serious reason for that, and I believe that's a fundamental flaw in our system.

They are afraid to come before a committee of this Legislature, composed of government members, and opposition members as well. It's a three-party committee. It's not like they're tying themselves in to any political party. We're asking them to tell us, as members of the Legislature, what is happening in the hospitals, and they're afraid to do it. I think that that's a very serious flaw.

To be gentle, we can say there's an old-boy network at work here; but the other side of that coin is that if you don't belong to the old-boy network, your hospital suffers and the people in your area don't get the same kind of service as they do in another area. If you take that to its extreme, and you don't have to push it very far to get there, that's a most serious political problem.

**Mr. Wetherill:** If you respect my position as a professional who has worked with this situation in a number of countries and in provinces of this country, I find that to be the same everywhere. I didn't find Ontario to be unique in that regard. It is a serious problem, but Ontario is not unique by any means. If you're talking about locked door negotiations, other provinces have, from my experience, done quite a bit of that. In this province I have noticed more open door discussion, more opportunity for that kind of discussion. My question is, why is it that people send a letter but cannot appear personally? Is it because they feel they are threatened by government, or is it because they just happen to be people—and it doesn't matter whether they're in Ontario or anywhere else—they happen to be people who just feel threatened? I don't know the answer to that.

**Mr. Breaugh:** Mr. Conway, Mr. Turner and I spent last Wednesday with a group of administrators at an OHA meeting. I must say that I found it a very fruitful meeting. It was put very bluntly there. Mr. Conway and Mr. Turner may disagree, but I think the consensus was clear, and put very nicely by one of the members present, that it was unrealistic to expect someone to provide information to a committee of the Legislature on one day and then go back to the ministry the next day and seek funds. They had an obligation to get that money for their hospital however they could, and the rules of the game here were very clear. You could not present information to a committee of the Legislature and get away with it.

**Mr. Wetherill:** I'm surprised to hear that.

**Mr. Breaugh:** I'm not.

**Mr. Acting Chairman:** Mr. Turner.

**Mr. Turner:** Just to follow that: based on your experience, and your integrity and your involvement with the system, is that, in your opinion, a reasonable type of statement to make or a reasonable attitude to convey? That people will be penalized in fact? Have you had experience with that? If they come here and complain on behalf of a hospital are they going to get 10 per cent, 20 per cent, 50 per cent less than they get now?



Mr. Wetherill: In very general terms, I think all of us here know that can happen. Old-boy networks exist, though not as strongly as they used to. But in terms of health care in this province, I have no knowledge of specific examples where this has been brought about and I'd be pretty surprised if they were there. I may also be ignorant of the fact that it's taking place, but I personally have not come across it.

Mr. Breaugh: I personally have.

Mr. Turner: Cite an example.

Mr. Breaugh: How about last Wednesday when we went to Chatham, to the OHA meeting? What was your reception when you said the ministry was very open?

Mr. Turner: The charge was made, Mike, and the seed was planted by you. Somebody agreed with you.

Mr. Breaugh: Somebody? If we had taken a vote in room what do you think the vote would have been? It would have been about 103 to 1, and you'd have had the one opposition vote.

Mr. Turner: I just asked Mr. Wetherill, based on his experience, if in fact—

Mr. Breaugh: As a consultant for the ministry.

Mr. Turner: As a consultant for several ministries in several countries, not for this ministry.

Mr. Breaugh: So we get parity with Uganda.

Mr. Turner: Oh baloney!

Mr. Breaugh: Don't push me to extremes, Big Jack.

Mr. Turner: Don't be so negative.

Mr. Acting Chairman: Carry on with the questioning, please. Mr. Wetherill has to leave.

Mr. Turner: Mr. Wetherill, you have indicated that the winds of change are blowing in the health-care system around the world. You have alluded to public health, you have alluded to community involvement and so on. In your opinion, is the direction in which the Ontario Ministry of Health is proceeding at this point in time the right way to go? Would you see other directions being of a more positive nature?

Mr. Wetherill: The direction in broad terms is correct. There are very few examples of ministries moving this way with such positive approaches.

Mr. Turner: Very few examples in other jurisdictions?

Mr. Wetherill: Yes. There are, however, areas within that direction where ministry

officials must look more carefully at the things that they do. It's my understanding that they are; they're bombarded by guys like me, and those in the field, to make sure they do.

Mr. Turner: That was going to be my next question.

Mr. Wetherill: But this direction is positive.

Mr. Turner: Further, based on the experience which you have had, not here but in other places, do you run across an attitude, if you will, of people in various communities who want to have the same level of service, or a similar level of service, as that which is available to people living in a larger community?

Mr. Wetherill: Most of the communities that I deal with now are looking for some kind of parity, some kind of equitability in terms of service which meets their needs. There is less of this business of those in a small community saying, "Why is it that the big community always gets everything and I get nothing?" or communities' spokesmen saying, "They've got this expensive equipment in Toronto to do all these things and we have not, therefore I have to send my patients to the metropolis." There is less of that now.

Many of these people are now saying, "That's where it should be. Let us look at these other levels of care and service that we are entitled to regardless of the size of the community." I'm talking about home care, day care, hostel accommodation and so on; there's more of that and that's positive.

I still go into the communities where a past mayor or mayor-elect running for power or wishing to maintain it will make a statement in the opposite way, and there are statements made by individual community members, but generally speaking, from my experience and the experience of my colleagues and those I relate to, that change is coming about; and it's positive.

Mr. Turner: There seems to be another direction within some communities. They are saying, "In order to attract the level of medical expertise which we would like to have we have to offer the physicians more." Is that a valid concept?

Mr. Wetherill: I think there is some validity to that. Any physician, let's take one in a small rural area, needs some basic things, he needs some basic equipment. Some of those facilities out there, which I'm sure the ministry is only too well aware of, is old and it's rapidly moving into obsolescence. Obviously, a group of trustees realizes the need to put funds into securing more up-to-

date equipment; not that it does much to increase service but it does a job that it's supposed to do more efficiently, and they're looking for that kind of equipment, that kind of expertise. If physicians find they have rusty scalpels, they're going to look for a place where they get clean scalpels.

**Mr. Turner:** You're talking about the basics. I was talking about a bit more than that.

**Mr. Wetherill:** If a community wishes to set up, say, a cardiac-care unit—and such an instance recently came to my attention in a community which I cannot reveal at this time because I think there was too much disagreement to give a community view. There were certainly a lot of people there saying they must have a cardiac-care unit, in a community that has about 20,000 people. That seems a bit strange to me. They need a cardiac-care system, not a unit; and that means tying in to the other levels of care in the bigger metropolis so that they can get physician input when required. That requires travel and that requires funds.

**Mr. Turner:** In your opinion, are these communities going to be willing to accept that concept?

**Mr. Wetherill:** I think so, in time. But also, I'm afraid I have to admit some of them need a bit of sticking, because they won't move otherwise.

**Mr. Turner:** By placing more emphasis on public health, are we kidding ourselves into thinking we are going to be promoting "wellness", as you term it?

**Mr. Wetherill:** I do not believe that Canada is promoting "wellness" as much as the Lalonde report said. I've actually listened to a presentation and received a paper from a Toronto doctor who said: "Whatever happened to the Lalonde report?" I think he's got a very good question there. If I look at Canada's use of the Lalonde report, and I don't know how many copies sit on shelves gathering dust, I have to assume people are not reading it. The odd jog around the park is not lifestyle; that's paying lip-service until the next cocktail party.

**Mr. Conway:** They'll soon have a Crombie conundrum with which to deal.

[4:00]

**Mr. Turner:** Whatever that may be.

**Mr. Wetherill:** The USA has taken more advantage of the Lalonde report than Canada, and Lalonde's report is more than used in Europe. That comes from pretty high level health professionals. I think there's a basic question to be asked of the federal

health authorities in that regard. They wrote that document; what are they doing about it? I think that's a community responsibility.

**Mr. Turner:** How does the level of health care, say in Europe, compare to what we have in Canada, in your opinion?

**Mr. Wetherill:** That's a very difficult question to answer because there's so much disparity.

**Mr. Turner:** Is there?

**Mr. Wetherill:** It's said that in Britain there is a tremendous welfare system. Sure, if you like to go and look for it, but there are many people who need nursing home care in the Midlands of Britain who are not receiving that care. Geriatrics has become a Cadillac of medicine. I'm not so sure that we need move in that direction. Gerontology needs to be the consideration; total, not purely medicine.

**Mr. Conway:** Geriatrics has become the Cadillac of medicine?

**Mr. Turner:** He made a fine definition, a differentiation, which I find rather interesting, because that's the first time you've mentioned that today, or anybody has mentioned it.

**Mr. Wetherill:** I mentioned long-term care, which involves the elderly, and I had mentioned one or two specific figures there. With the increase in the number of elderly people, I think that one of the biggest problems we face in the future will be care of the elderly. There is so little co-operation on the part of communities with respect to the elderly. There is a lot, but compared to what needs to be done and what we need to be prepared for it is still not sufficient.

**Mr. Turner:** Thank you very much. Just to clear the record, so there won't be any misunderstanding, Mr. Chairman, on that very devious point about the isolation unit which somebody said Etobicoke lost because of whatever devious means it may have been decided; it was located on the recommendation of the university teaching hospitals.

**Mr. Breagh:** We always like to get your devious means clear. I would suggest, Mr. Chairman, that we dispense with the honourable member because we had ministry staff advising the member on what questions to ask the ministry's consultant.

**Mr. Chairman:** Mr. McClellan.

**Mr. McClellan:** I think we've had a good discussion, Mr. Chairman. I know the witness has a time constraint. My questions have basically been covered; I'll forgo further questions.

**Mr. Chairman:** Mr. O'Neill.



**Mr. O'Neil:** Some of mine have been covered too, by those that John asked; but as you likely know, we've had a lot of these smaller hospitals appear before us over the last week or two. They're worried that since they are in small communities, a lot of the life of the community has been built around these hospitals. What advice would you give to these hospitals? Should they be kept at a certain level? Should it be demanded that the government leave them at that level and not take the number of beds below that level? What advice would you give to a hospital like that?

**Mr. Wetherill:** As I said earlier, we're looking into and doing research on small hospitals, and we believe they have a very big future. But that requires the small hospitals to become more imaginative in terms of what they can provide as health complexes. Not as hospitals in the status quo, traditional sense, but encompassing and relating more to public health, relating more to the VON, Red Cross and so on. It's their major purpose, as far as we're concerned, with the help of the ministry and advisers and district health councils, to develop strong bases from which they can provide more appropriate levels and ranges of care. I think that's going to come about. As I understand it, the Ministry of Health, and the minister personally, have requested that consideration be given to the specific requirements of small hospitals, because ministry officials have expressed concern that these hospitals must be looked at carefully in terms of their future. I think a great deal of the initiative lies on the shoulders of the administrators and the trustees, well supported by their community, to come up with plans for their future. I don't mean one-year-by-one-year budget plans but long-range service plans.

**Mr. O'Neil:** Again I see a bit of a conflict in what you're saying. Long-term plans as to what they're going to do, and you mentioned the Red Cross and VON, but are you saying then that a lot of the doctors should go to the larger centres, that a lot of the equipment shouldn't be in the smaller hospitals, but should only be in the larger hospitals; or that they shouldn't have as many active treatment beds? You can't close down a 50-to-100-bed hospital and say we're going to have your VON work out of there or the Red Cross work out of there. What do you see as the future for the small hospitals?

**Mr. Wetherill:** I think, on all those things you mentioned about physicians moving to larger centres, that there need to be physicians in large centres and small centres, but they need to be related to the appropriate

levels of care. VON suddenly can't take over a small hospital, but the small hospital can surely co-ordinate and communicate with VON in terms of what service needs to be provided to those people who are at home, who can receive home care and visit a day-care centre, which could be a specific piece of action on the part of a small hospital—large hospitals too.

More of that is now becoming clear to communities, that they can actually develop those kinds of services; certainly in the areas I'm working in.

**Mr. Pope:** A supplementary: I guess our problem is the phrase "appropriate level of care." When you get down to a problem, it's another word and another definition.

**Mr. O'Neil:** What would be your definition of "appropriate level of care"?

**Mr. Wetherill:** One that suits their actual needs, which can be clearly identified. I did give you a specific example earlier of a small hospital of 33 beds, reduced from 50 beds, where we actually found that 15 could be in an active inpatient bed, two in a chronic care bed, two in a home for the aged; and I couldn't be more specific than that. Those levels of care are appropriate to those people's needs, but they are not necessarily getting that now.

**Mr. O'Neil:** So you're saying that some of these hospitals are above the level at which they could be working?

**Mr. Wetherill:** They have more than what's required for some patients and not enough of what's required for others; that's where these guidelines need to be broadened. A single guideline of so many beds per thousand is useless if left on its own.

**Mr. Turner:** I just wondered, and you correct me if I'm wrong, you're not leaving the impression in anybody's mind, I hope, that you're suggesting there isn't a place for the small hospital?

**Mr. Wetherill:** I hope I'm leaving the impression that there is every place for the small hospital.

**Mr. Chairman:** I think one of the concerns in terms of the smaller hospitals, Mr. Wetherill, is that with the application of the formula, at some point they will get to the point where the ministry will say, "I'm sorry, you're not big enough. You are not really efficient in terms of a viable operation. You should close down entirely." Do you see that happening in small rural areas?

**Mr. Wetherill:** Do I see the ministry saying that you are no longer efficient and therefore we'll close you down? No, I do not



see that taking place. I know the ministry has looked at one or two small hospitals. Some investigations may show inefficiencies, there may be a requirement for replacement in the case of a small hospital, but if the ministry were going to pursue the route of looking at progressive care more than just inpatient, active care, looking at the alternative forms of service available, then small hospitals—their names will probably change because hospital is too narrow and psychologically it's a problem—but they will become stronger and they will provide, and be part of providing, a much broader range of services which are more appropriate in terms of the needs of those communities. So though the destinies of small hospitals at this time might appear to be precarious, on the edge of a cliff, I think the mechanism is now developed and the attention being given to make sure that these small hospitals can develop, not as status quo entities as they have been but as much stronger units in terms of meeting the overall needs of the communities they serve.

**Mr. Chairman:** I want to thank you, Mr. Wetherhill, for your time and for your contribution. I am sure the committee has appreciated your attendance here and the information that you've conveyed.

**Mr. Wetherhill:** I think I'd like to say that I have tried to be as open as one can be in terms of this committee, because I do believe that people should speak up. Thank you very much.

**Mr. Breagh:** If only John could get his questions straight there'd be no problem here at all!

**Mr. Chairman:** Now, then; Mr. Sarra please. Mr. Sarra is from the Ontario Public Service Employees' Union. I believe you are the political liaison officer, Mr. Sarra?

**Mr. Sarra:** That's correct, yes.

**Mr. Chairman:** Do you have an opening statement?

**Mr. Sarra:** Yes, Mr. Chairman, I'd like to thank the committee for giving us the opportunity to make a presentation today.

The Ontario Public Service Employees' Union has decided to make this presentation to the committee on the subject of cutbacks in active-treatment beds because we believe the Ministry of Health has embarked upon a course of destruction of the Ontario health-care system. Our members are concerned, both as citizens of the province who are inevitably harmed by the cutbacks, and as workers in the public sector who are intensely committed to and involved in the

delivery of good social and health-care services in the province.

It is clear that the Ontario government has chosen to attack a sector of society whose members are least able to defend themselves, that is the ill. The squeeze being perpetrated within the health-care system is one fundamentally concerned with dollars. The government has set its priorities: corporate giveaways in the order of \$300 million in interest-free loans to the uranium companies and \$100 million in subsidies to pulp and paper companies, are but two examples of government priorities which rank higher than the health of Ontario residents in terms of commitment of those public dollars. We understand that financial constraints are the inevitable consequences of an ill-managed economy, however we seriously question whether these restraints should jeopardize the health-care system in Ontario.

A close look at the issue of active-treatment beds perhaps clarifies the reason for our great concern about the delivery of health care. The active-treatment bed allotment guidelines were introduced in November 1978 as a rationalization of strained financial resources. The new guidelines are based upon per-bed population, not upon the actual active-treatment needs of communities across the province. The formula appears itself to be arbitrary and ill-based.

In response to a question in the Legislature on cutbacks of active-treatment beds in Wingham and Goderich, the minister gave the rationale that, "there was a need to consider conversion of beds for chronic purposes and to recognize that, in fact, they are being used for chronic purposes. Our goal is to have that number of beds available for active or acute purposes, not a fixed percentage which would at any given time be tied up by patients whose needs are other than for acute care."

These seemingly well planned statements were accompanied and contradicted later by others in the House. I'll quote from a later statement: "The ministry is not able to determine the number of chronic-care patients who may be occupying an active-treatment bed from current information and reporting systems. Accurate information could be obtained only by a medical assessment of each patient occupying an active-treatment bed."

We can only assume that the minister has arbitrarily determined the per-bed population formula without any data on actual active-bed requirements or the number of people who may require chronic care.

I provided a table in the presentation that demonstrates clearly that Ontario currently has the second lowest per-bed population

ratio in all of Canada—it's superior only to Newfoundland—yet the Ministry of Health plans to further decrease the ratio each year until 1981 when, if Ontario still has a health-care system, our bed-per-population ratio will be the lowest in all of Canada.

[4:15]

This serious reduction of active-treatment beds is accompanied by acute-care budget increases of 4.5 per cent in this fiscal year. With the hospital deflator at 7.8 per cent, this budget allocation is ensuring hospital services will be further cut back. The end result is the final destruction of good health in Ontario.

Mr. Timbrell, in his remarks to hospital officials in January 1979, stated that the objective is to help ensure that all of us, the government, the health system and the people we serve, receive the best value for money expended.

OPSEU is confident that no member of this committee would wish otherwise. However, the key lies in the final clause, in money actually expended. If we are to maintain a decent health-care system we shall have to commit the public funds to guarantee equality of access and service. We believe that it is the responsibility of the Ontario government, through our tax dollars, to provide such funds. This ensures universal access to health care, no matter what the financial status of an individual in society. We therefore do not endorse concepts such as user fees for health care. We consider the imposition of a user fee for chronic care after 60 days as a further destruction of such universal care. Those who are chronically ill are the least able to bear the additional medical costs of these user fees. It leads one to question for whom the health care system is designed.

The report of the joint advisory committee of the government of Ontario and the Ontario Medical Association on methods to control health-care costs states that future closing down of hospital beds not be undertaken by the ministry without adequate consultation at the local level. Yet representatives to this committee from hospitals such as Wingham and Meaford, have stressed the lack of local consultation or sensitivity of the ministry to individual needs of isolated community health services.

It is ludicrous that local hospitals, such as Metropolitan Hospital in Windsor, have been financially squeezed to the point that they must take the Ministry of Health to court before they are assured of decent health care for Windsor residents. One can only speculate on the number of active-treatment

beds that could have been paid for by the legal costs which will be finally incurred by the ministry at the Supreme Court. Most hospitals do not have the resources to take the government to court, to guarantee that the minister fulfills his mandate under the Health Insurance Act to promote the health and physical and mental well-being of Ontario residents as well as ensuring adequate health services in hospitals.

I would like to caution members of this committee against the minister's boastful statements that he has set a fine example in times of financial restraint. If we examine his supporting evidence, it gives us further indication of how health services are suffering across the board. To refer once again to his January 19 statement to hospital officials, he urged them to accept the new restraints in the same vein as his accomplishments. His cited example was OHIP staff reductions of 21.5 per cent in the last four years, with increased case claims of 25 per cent being processed.

The minister failed to mention a few ramifications. Staff at OHIP offices provide a great service to our community through their overburdened work load. Yet their efforts are only human and the result of their bearing the brunt of staff cutbacks has meant backlogs of OHIP claims processing. Interestingly, this is a common complaint of doctors opting out of OHIP, the fact that processing claims is too time-consuming. The minister failed to take proper credit for this destruction of the health-care system.

His solution? The staff have received directions that at times of great backlogs, procedures are to be relaxed and doctors' claims are to be processed first. Although this may marginally encourage doctors not to opt out, the burden falls upon the thousands of individual claimants who are pushed to the one side and who are least able to protest this treatment. The government, for all its unused legislative powers to ensure doctors remain in the publicly-financed health system, is quick to shift the burden to the ill people in this province. We would suggest that hospital officials would be insulted by the minister's suggestions of leadership in the field of restraints, and we caution the committee to carefully assess whether policy planning, in terms of this new bed allocation formula, will have similar ill consequences.

The minister has estimated that in 1979-80, in the first stage of lowering bed-population ratios, that 890 active-treatment beds will be declared surplus. Hospitals will receive \$12,000 per surplus-bed budget reductions respectively. Despite assurances by the min-



ister that chronic-care alternatives will be developed, OPSEU questions this commitment in light of other social service cutbacks.

The minister's January announcement included a commitment to expand efforts to co-ordinate placement of chronic patients in nursing homes, homes for the aged, daycare centres for senior citizens and chronic hospital care; yet in Metro Toronto alone capital funds on homes for the aged have been frozen. Staff reductions in these homes, in the amount of 93,000 this year alone, will ensure decreased services. The proposed 40 additional home-care spaces in Metro to supplement the 24 already in existence, have been totally cut by budget restraints, despite the fact there are 209 people still on a waiting list for such housing. We seriously question whether the minister believes the needs of patients will be met through this form of alternative accommodation.

These are a few of our concerns about the ministry's cutbacks of active-treatment beds. We believe it was essential for us to join with residents, hospitals and communities in protesting these cutbacks to your committee. We are not opposed to the deinstitutionalization of chronic-care patients, but we are firmly opposed to the systematic dismantling of a health-care system which has no community support in place to meet the requirements of these citizens.

We believe this move by the government has been ill-planned and done with little or no true analysis of the medical needs of active- and chronic-care patients. The weaknesses in the decision are many in number. To automatically label a patient as chronic care after 60 days fails to recognize the different needs and recovery rates of patients. To give small hospitals a 10-bed allowance for only one year is to forestall but not correct the serious problems they will face next year in order to have their small and inflexible operations meet the new guidelines. Northern hospitals cannot afford even greater distances between residents and medical treatment.

These are a few of the continually cited problems of the ministry cuts. They serve to disrupt communities, increase unemployment in small centres, decrease the level of active treatment and undermine the principle of universality of access to health care in this province. We are concerned. We are counting upon the equal concern of members of this committee to ensure that the quality of health care in Ontario does not suffer further.

**Mr. Chairman:** Thank you, Mr. Sarra. Mr. Breaugh.

**Mr. Breaugh:** Yes, I appreciate the words Mr. Sarra has put before the committee.

OPSEU is one group that seems at least willing to present, in a very open and public way, their point of view on the program, the formulas and the guidelines. There is a difficulty, but I think we all are very open about it. Without question there will be some conflict of interest on this issue for a union representing workers in a hospital, because there is the added dimensions of being concerned about the jobs of people who work there. But I must say in the presentation today I haven't seen much, of an obvious nature at any rate, that says the first concern is with the people's jobs and health care is only a secondary concern. In fact I read it to be exactly the opposite way around. The first concern is for a good health-care program, and then the obligations that any trade union has to represent its membership and go for job security. It seems to me to have been put into proper perspective.

In my discussions with individual members of this and other unions representing hospital workers, I get an increasingly large number of reports. The working conditions are such that there is in fact, on a day-to-day basis now, some threat to workers. People I know who are working in a health-care institution not far from my riding are rather persistent now. They are being asked to do work on a ward that is short-staffed and that puts them into some physical danger. Similar kinds of reports are coming from other institutions. I'd like to ask, Mr. Sarra, if your union, in its presentation today, wants to make any kind of statement about that. It's a concern of mine, from the point of view of the patient and from the point of view of the health-care worker who is there. For the first time in my memory, we are getting reports of wards in general hospitals left with two people working. Should one of them answer the phone, go for a coffee, in any way be distracted from that ward, there is only one person left looking after 20, 30 or 40 people. That is posing a serious problem just in terms of the level of care. To be precise about it, I see that in hospitals in various parts of the province, people are suffering falls, burns or whatever, because there just isn't anybody there to look after them. From your perspective, how prevalent is that?

**Mr. Sarra:** I'd like to place one thing in context first of all. You started off talking about our members' jobs and how this brief did not emphasize that. We usually come here because our members' jobs are being cut back and threatened and hospitals are being closed. To be very honest with you, a very small percentage of our membership is really affected by the active-treatment-bed hospi-



tals. That's not to say we don't have locals in those hospitals, we do; but it's a small percentage of our 60,000 membership.

However, what you were just speaking of is one of their general complaints. With one or two people on a ward, if one is sick or if one has to go home, you are left in very serious and, at times, dangerous situations. One as to physical well-being personally, but also from the point of view of having to provide health-care services to the patients in the ward. It is a really very strained situation for them.

**Mr. Pope:** Could I get a supplementary?

**Mr. Breaugh:** Yes.

**Mr. Pope:** Personally I am glad you are here because I wanted to have some discussion. Is there any up-to-date information on how many people or employees have been let go because of the government budget allocation system? Secondly, you talked about danger to personnel because of budget cutbacks. Could you give us, in some detail, numbers of your members or hospital employees who have been injured because of cutbacks?

**Mr. Sarra:** One of the main problems in answering your question is that in terms of cutbacks what the researcher was able to do before we came to this committee was actually very small because we did not have prior indication this committee would be meeting.

**Mr. Pope:** Right.

**Mr. Sarra:** In terms of our membership at this time, I am only aware of two cutbacks that have affected our membership. We don't, very honestly, represent a large portion in active-treatment-bed hospitals. Most of our hospital organization is in the psychiatric wards.

I do know of some instances of danger to our members in those circumstances. The dangers are much the same, although a little more refined in a general hospital. Whereas late at night you have one nurse on a ward, you have the physical threat of rape. The problem in psychiatric wards is that's quite exacerbated and I am aware of instances where that has happened. In the active-treatment hospitals we represent I am not aware of any instances, to be quite honest with you. But the threat and danger still exists, if not to our membership because of the small number of organizations we do have in that area, then it does exist in a theoretical sense.

[4:30]

**Mr. Breaugh:** For the benefit of the committee, let me just put to you some of the problems that have been put to me in this

regard. Maybe Mr. Sarra would like to comment on them.

In a hospital in Hamilton, during a lunch period, two nurses were on a ward and one of them was called to the phone and while she was gone an elderly patient spilled a pot of tea and suffered a burn, not a serious burn but a burn nonetheless. In normal circumstances that would not have happened because there would have been more than two people on that ward, there would normally have been three.

**Mr. Pope:** Were there burns from spilled coffee in hospitals before the government cutback program?

**Mr. Breaugh:** Did I say that?

**Mr. Pope:** No, I'm just asking you.

**Mr. Breaugh:** See, if you push me I'll say that.

**Mr. Pope:** Okay, say it.

**Mr. Breaugh:** If you want to get radical, if you want the rhetoric, you can have it. If you want it, shout, and I'll give it right back to you.

**Mr. Pope:** Okay.

**Mr. Breaugh:** Thank you.

**Mr. Turner:** Don't be testy.

**Mr. Conway:** He used to be the independent member for Cochrane South; take it easy.

**Mr. Breaugh:** He wants back in that cabinet awfully bad. I think you may wind up with the World Hockey Association, and you know where they are.

**Mr. Pope:** That may be true.

**Mr. Breaugh:** As a low draft choice.

There are other kinds of problems, which seem to be rather minimal and I suppose in some cases may be written off as well. The public is just going to have to suffer this kind of inconvenience. In the day-surgery unit, which had recovery areas, someone fell out of a chair. It's not an abnormal situation, but that person was not found for some 20 minutes because there weren't enough nurses in that unit.

Many hospitals reporting to me now, say that administrators, being the kind of people they are, are doing various stunts in order to reduce the budget. For example, they are reducing the number of hours worked so employees become temporary employees or part-time employees instead of permanent employees. That means a substantial saving in the benefit section of a contract. A number of people are getting compulsory vacations, for longer periods of time; really they are facing temporary layoffs and then being recalled only on a spasmodic basis. It seems to be a

growing trend. It also happens to be one of the few options an administrator has at his or her disposal. When there's a fixed amount of money put in place and the operation, in general, must be carried on, you don't have many options. You can lay people off, you can fire people; both of which would be probably very noticeable. The only other options you have are to use the smaller and the less dignified tricks of the trade: to see that people only get called in for a minimum number of hours, to see that they're laid off with some regularity, to extend vacation periods; a number of things like that.

Your union, as you say, tends not to represent active-treatment-bed hospitals though you do have some membership there. Are you having many problems of that kind? Is that resulting in grievances and will it result in some considerable labour unrest if the trend gets worse and continues over the next year or 18 months?

**Mr. Sarra:** One of the most unsatisfactory things with the labour process for our membership has been the fact that when you give an administrator a five per cent increase in his budget there's not much more you can negotiate across the table. So that doesn't lead to a membership that is happy in its work. The quality of working life in these environments goes down, which means that the level of service, almost automatically, has to go down as well. It has to have an effect. These are people, they are not machines; they are affected by their working environment.

Hopefully our membership might be better represented and have higher benefits than some other people who are working in the unorganized sector in the health-care and active-treatment hospitals, but their daily interaction with patients and their level of service to patients will definitely be affected by that.

**Mr. Breaugh:** It's been kind of a traditional development, I suppose, that when strikes occur they are sometimes over monetary matters found at a bargaining table, but very often they are over cumulative grievances that don't get resolved, arising of unhappy working conditions. Memberships find the only real occasion to make their feelings known is when negotiations come up. I know in my experiences in the trade union movement, on both sides of the bargaining table we were always very aware that if the membership at large was encountering day-by-day problems that were not resolved sooner or later you would pay the price for that. Do you think that hospitals in this province are going to pay that kind of a price?

**Mr. Sarra:** In the build-up that has been going on for a number of years, in the continual attack on the hospital-care and health-care system, yes, they would; it's inevitable.

**Mr. Turner:** That's an interesting point and it's something with which I've had some experience and feel very strongly about. Mr. Sarra, would you agree that is not a problem that exists solely in the bargaining unit of a hospital, but rather is a fundamental problem within the bargaining process as we know it today?

**Mr. Sarra:** Yes, but I think it's exacerbated in the health-care sector with the hospitals because this has been a traditionally lower paid sector.

**Mr. Turner:** Yes. I just wanted your view.

**Mr. Sarra:** It can exist anywhere.

**Mr. Turner:** I'm just wondering if you would not agree that perhaps it's something that—

**Mr. Breaugh:** What we found, for example, was that when I was on the council in the city of Oshawa, sitting on the other side of where I would normally sit at the bargaining table, we were extremely aware that if we weren't prepared to deal with grievances—even though they might have been politically embarrassing, tough to handle and awkward; I don't care how you deal with the grievance, you're never going to satisfy them 100 per cent of the time unless you give them the grievance 100 per cent of the time—but the important item was that if you didn't keep the grievance procedure moving, if your employees weren't satisfied they at least got a fair shake on a day-by-day basis, the next time you came around to negotiations that might be the only occasion they had in the two- or three-year period to make their unhappiness felt, and they would.

**Mr. Turner:** I'm not disagreeing with you. I just wanted Mr. Sarra's opinion, really, to see whether he agreed or disagreed with what I understood.

**Mr. Breaugh:** I think the problem right now with people like OPSEU may well be that it's going to be tough to put out a lot of grievances on who gets laid off and who gets to work how many hours, and who goes from a full-time employee to a part-time employee. It's tough to win that kind of a grievance. But the cumulative effect may be that the next time they sit down at a bargaining table, that's going to be a much tougher unit to try to bargain with. Even though the negotiators at the table may recognize the economic realities of the situation, and go for a settlement they normally



wouldn't take, when you put that vote to a membership, that membership then takes out its anger so you may see a problem that's happening in hospitals today. You won't see the end result of that until the next set of negotiations, and that's my concern. They may not be able to do much about it today—

**Mr. Turner:** Would you agree that that's the weakness in the present bargaining system as we have it today?

**Mr. Breaugh:** I'm not sure. I'd describe it as a reality rather than a weakness.

**Mr. Turner:** There is a weakness, whatever.

**Mr. Breaugh:** I wanted to get to it, because some of your members will be faced with a conflict situation. I think there wouldn't be much argument for many people around this table that there are economic decisions that will be made, probably on the advice of a management consultant, probably on a cost benefit basis which says we shouldn't have five kitchens in operation in a hospital, we should have one centralized, mechanized kitchen; we shouldn't do the laundry in five hospitals in an urban centre, we should ship it all out to one central source—the pooling effect. All of which looks nice on paper, but in the day-by-day reality in which your members live, it means somebody, or some group of people, will lose a job. What kind of a position would your union be put in that situation? Or have you in the past?

**Mr. Sarra:** I'll be responding from a generalized point of view, with my background in the labour movement. Our first instinct is to protect our members' jobs, very clearly. What we as a union look for is the point of job security for a membership, and making sure that management in situations provide decent alternatives for memberships, if they're not willing to maintain job levels. We are not unopposed to most of those changes, but the effects of most of those changes at times do have a detrimental effect on our employees. Our employees normally respond at negotiation time concerning those effects.

**Mr. Breaugh:** Could I put to you what may seem to be an odd, perhaps unfair question? If I were a hospital worker in Ontario and my settlement rate tended to be around the four, five, six or seven per cent level, and my income tended to be around eight, nine or 10, if I was lucky \$12,000 per annum, and I was looking at others in the health-care field—administrators, practitioners of medical sciences of various sorts—whose income levels are in the upper \$20,000s at the very least and most likely upper \$30,000s or upper \$40,000s, and I was being asked to share in a restraint program, I might express

immense unfairness about the whole process. In other words, if somebody has to take six per cent, give me six per cent of \$50,000 instead of six per cent of \$10,000. How widespread is that feeling among your membership?

**Mr. Sarra:** In the health-care sector especially, I think they've been hit harder by restraints than any other sector. They've been traditionally in lower-paid jobs. Their increases over the last few years have been quite low. The continual frustration that that brings around places them in a more militant mood, and places them in a position of feeling they're getting gypped in society and that they will at one point bring that frustration forth to the management.

**Mr. Breaugh:** I want to point out one other area of kind of management-labour relationships where I think there may turn out to be severe problems. In many places, the people you represent in the hospital pecking order would be seen to be, in economic terms and in social terms, on the bottom of the list. Yet in terms of where to make cuts, they always seem to come out to be on the top of that list. How much longer would you guess that your membership is prepared to accept that?

**Mr. Sarra:** To be honest with you, I couldn't give you a clearcut answer and I'm not too much further into the future. I can assure you of that point. One of the frustrating facts for our membership is that they do tend to feel that they are at the bottom of the pile. They're getting cut, and the administration does continue to grow with much higher salaries.

**Mr. Breaugh:** One of the oddities, and this may be because I was born in a small town in eastern Ontario, is that I notice even in the community where I live now there is kind of a sense in certain parts of the community, not the one that I live in, but in certain parts of the community, that somebody who might be an organized union employee in a hospital is down at the bottom of the social economic scale.

In the eastern Ontario community where I was born, we wouldn't do it that way. We would simply say, "that's the guy who lives next door." None of this other socio-economic stuff enters into the picture. It's just simply another human being who has a job in a hospital. I must say that though the doctors have eminent positions in small rural communities, everybody else is roughly in the same classification, and they don't make those distinctions. Do you suggest that in the very near future we are going to see con-



siderable alteration of that? Are your members going to be content to be the people who wash the floors and the first ones who receive the cutbacks, that kind of stuff?

**Mr. Sarra:** Most of our membership is in the paramedical area. Most of them tend to be very highly technical, highly skilled individuals, and very highly educated as recent years go on. That's the kind of thing that they will unfortunately not be prepared to accept for very much longer.

**Mr. Breaugh:** Let me just finish with this one question.

**Mr. Conway:** I would like to ask an explanatory supplementary. Could you just give us an idea of the kind of people who are in that category that you represent in your particular union?

**Mr. Sarra:** We have X-ray technicians, we have nurses in some areas, we have pharmacists in some areas. It's a very wide range.

**Mr. Ramsay:** One quick supplementary: I came in just after you started, but in listening to Mr. Breaugh I got the idea that you are representing the cleaners and the kitchen help and that sort of thing.

**Mr. Sarra:** Not to a large extent in active-treatment hospitals.

[4:45]

**Mr. Breaugh:** Let me put to you a question I put to a consultant who was just before the committee. It has been discussed at some length that many of the people, for example whom you represent, do things in a hospital setting—in theory, I guess, under the supervision of someone else with much more qualifications: a doctor, a nurse, whoever. But for all practical purposes, where it happens, they do the job. One of the things that has been discussed for some time is to alter the rules of the game so they not only do the job, but they get paid accordingly. Somewhere in the balance of that, there is bound to be, there has traditionally been in other jurisdictions, a considerable cost saving.

Would one sensible solution to our problems, if we had them, about funding health care in Ontario be to rearrange the designation of who does what? In other words, do we really need somebody to sign the name at the bottom of the page in order to accomplish the work? In the hospitals I visit, I don't want to get caught up in Mr. Ramsay's trap here, but I see the semi-technical staff do the work. Someone comes around later on in the shift and signs the paper.

It strikes me that other jurisdictions have clearly established that that rearranging of

who is allowed to do what, and assume responsibility for that, has considerable cost savings. Little places like Saskatchewan, as an example, can afford a dental-care program by using that technique, and big, wealthy Ontario can't.

**Mr. Sarra:** I think, clearly, that's the answer in terms of one cost saving overall, and in terms of individual job satisfaction and enriched daily working life. I think it also will make the operation more efficient at the same time.

**Mr. Ramsay:** It was suggested that the people you represent are in the wage category of \$8,000 up to \$12,000. Just what wage categories are they in?

**Mr. Sarra:** I would say \$8,000 to \$15,000 would be more accurate.

**Mr. Ramsay:** Could you just elaborate a bit, sir, if you don't mind? The X-ray technician makes how much, and a paramedic makes so much, and a nurse makes so much?

**Mr. Sarra:** They really vary from hospital to hospital. To give you one rate is not being realistic.

**Mr. Ramsay:** Who would make \$8,000?

**Mr. Sarra:** It would be very easy for me to say cleaners, and I'm not sure that we represent some cleaners in the active-treatment hospitals.

**Mr. Ramsay:** Thank you, sir.

**Mr. Leluk:** Just one point of clarification: I was very disappointed to hear that you include pharmacists among the paramedical staff in hospitals, lumping them in with floor cleaners and what have you, not because I'm a pharmacist, but, Mr. Chairman, merely because pharmacists are professional people. I've just recently had a series of letters, as I'm sure some other members of our Legislature have, from pharmacists who don't want to be lumped in with technicians. There's quite a difference between a technician and a professional person. How would pharmacists come to be lumped in with your paramedical staff?

**Mr. Sarra:** That happened by way of the laws of Ontario. Our organization doesn't always provide us with the most satisfactory answers. But in this case, the Ontario Labour Relations Board has ruled that pharmacists are part of that organization. Very clearly, a large part of the bargaining unit we represent across the wide sectors could be placed in the professional category, per se. We tend to see the reverse happening in a lot of areas. More and more professional people are saying, "I would love to be part of your union."

**Mr. Leluk:** But have you people been aware of the disenchantment of hospital pharmacists, who have expressed very clearly, not only to myself but to other elected members here, their dissatisfaction in being lumped in with technicians?

**Mr. Sarra:** Most of the organizations we represent do have a paramedical staff. There's only one location I'm aware of where we do have a pharmacist in our bargaining unit. We may have others. Most of what we hear is dissatisfaction from pharmacists who work in a lot of the chain drug stores, in places where they don't have many of the same benefits they would have in other areas.

**Mr. Breagh:** Are you finished?

**Mr. Sarra:** Yes.

**Mr. Breagh:** I just want to finish up on this one note. We have heard this afternoon that the current minister is very open to ideas, and is searching out consensus among a great many people. It would strike me one of the people or one of the groups that you would at least ask whether it is aware of any ways to save money or to make hospitals more efficient would be the people who work in those units. I would quote as my example Mother General Motors, which puts little boxes all over the plant, and gives its employees bonuses of up to \$10,000 for ideas on how to make a better Chev.

**Mr. Conway:** I remember them well.

**Mr. Breagh:** It doesn't seem to work terribly well. But it seems to be a widespread and generally accepted program. Has anybody in the Ministry of Health ever approached you in a formal way, representing a great many people who work for the ministry, to make such suggestions, or to participate in programs of that nature in the great search to make their health care better, more efficient and more cost conscious? What role has the ministry ever asked you to play in all of this process?

**Mr. Sarra:** I won't say that they never have, but I am not aware of their ever approaching us with that attitude and criterion for change. I think that's the kind of attitude and criterion that is becoming commonplace in a lot of working locations now. It's the attitude that says, "Maybe the people who do the work know the best way of reorganizing that job situation." They may have approached us; I'm not aware that they ever have, and it's certainly the kind of thing that enriches the job satisfaction of the people who are working there.

You can take that one step further. Instead of approaching the people and asking them on a consulting basis, one of the newer

techniques is also to involve them in the decision-making process, possibly looking at active-treatment beds. I'm not even going to talk to you about involving the paramedical people in the decision-making process. I think clearly the issue is that the hospital administrators would like to be involved in the process; very clearly, they're being left outside.

**Mr. Pope:** Just a couple of questions. I want to thank you for appearing. St. Mary's Hospital in Timmins has had the benefit of the advice of its employees in the planning and construction of the new X-ray, emergency and laboratory facilities. That's one example which I think you might agree was very helpful. That process took place in 1975, by the way, before I was a member.

**Mr. Breagh:** Since then you have lost all contact with reality.

**Mr. Pope:** No, as a matter of fact, over the last few months with some of the problems in Timmins, some of the employees have been very helpful in giving advice and suggestions, so I think your point is well taken. I guess the basic question I have to ask you in that context is this: accepting the fact that any system can be improved, do you have any thoughts on behalf of yourself or OPSEU, as to what improvements you see the ministry could be making on its funding programs or in its use of hospital beds?

**Mr. Sarra:** At this time, clearly, the only answer that I'm going to give you on behalf of myself or on behalf of the organization is one that I think they should be more in a consulting role with the individual hospitals, and involving them in the process of determining. The 325-bed ratio may be good for some hospitals. Mr. Wetherill spoke of one individual hospital where there were beds that were waiting to be filled. I am also aware of other hospitals where the beds are very clearly in demand. At times, patients are kept in emergency wards and in hallways in hospitals.

In 1979, in Ontario we should not have patients in hallways. It reminds me of something out of a Dickens' novel, and it shouldn't be happening here today.

**Mr. Pope:** Well, okay. Would there be any other suggestions that you might have, other than this communication and this flexibility in their standards?

**Mr. Sarra:** I would say that the institutionalization, which was mentioned earlier by the previous speaker, is the way the province is passing the buck in terms of health care. It's really hurting. It's one thing



to say that we're going to let communities provide facilities. It's another thing to look around and see there are no initiatives by the government, either municipal or provincial, in terms of providing those facilities. You can pass the buck and move patients out of hospitals very easily. It's a simple process to do. As Mr. Wetherill said, there were 15 people who shouldn't have been in there, but you don't move them out before you provide other services.

**Mr. Pope:** So you don't have any evidence of a community service program being set up? Things like an emphasis on the public health sector and these kinds of things.

**Mr. Sarra:** As I mentioned in my presentation, in Metro Toronto these services are being cut back, not expanded. You have a waiting list of 209 people for some of these services. That clearly is not an area that's going to pick up the slack.

**Mr. Pope:** Do you see waiting lists as an indication of a failure of a system? I mean are you saying there should be no waiting lists?

**Mr. Sarra:** It does amaze me that in 1979 we do have waiting lists for a number of what I consider very important and essential services. Waiting lists, per se, are not. If you're talking about cosmetic surgery that's not a real problem; if you're talking about someone who's 72 years of age and has no place to go and no one to look after them, and they're waiting for some home care, yes, that's a real problem, and we shouldn't have waiting lists.

**Mr. Pope:** Just one other point I wanted to ask you about. You were developing a point, about the fifth last page in your presentation, about claimants having to wait for OHIP payments, and something about the claimants who were least able to fight this system being jeopardized. I didn't get what point you were really making.

**Mr. Sarra:** In processing OHIP claims, doctors at times get priority. In other words, if you go to a doctor and that doctor bills OHIP for his services, his claim will be processed. But if you go to a doctor who has opted out of the plan and who charges you, when you personally, as an individual, make that submission, at times of backlog they move your submission aside to process doctors' claims because they want to keep doctors in the system.

**Mr. Pope:** In the process of your negotiations and discussions about some matters in the normal collective bargaining process, is this one of the items you've been trying to educate your own members towards, or is it

something that you've raised with the ministry?

**Mr. Sarra:** You mean OHIP claims?

**Mr. Pope:** Yes.

**Mr. Sarra:** It doesn't affect our members because our members personally are covered in OHIP—I'm sorry, I see what you mean, in terms of visiting individual doctors.

**Mr. Pope:** Right.

**Mr. Sarra:** It's a political decision that isn't made at the bargaining table, that is in terms of how OHIP does the work. For example, where we represent employees at 12 Overlea, or in OHIP, the people there who process claims, have as their job function the processing of claims; but it's a political decision as to what claim you process first. It's the kind of thing we would push across the table. We might mention it to them, but it's not the kind of thing that our members will be very hard on, unfortunately.

**Mr. Pope:** Would management determine what claims would be processed?

**Mr. Sarra:** Yes. Clearly management has ordered a number of times that doctors' claims are to be processed rather than individual claims; so that our members, if they do process individual claims, are put in the situation where they could be disciplined.

**Mr. Pope:** How long has this been going on, that you're aware of?

**Mr. Sarra:** I'm only aware of it in the last six months. It may have been going on for longer. The implication was that it has.

**Mr. Pope:** Okay, thanks.

**Mr. Chairman:** Mr. Turner.

**Mr. Turner:** Mr. Sarra, I want to thank you very much for coming here and I'm very pleased and happy that you're not—

Interjections.

[5:00]

**Mr. Turner:** However, I would like to just pick up on that OHIP thing. Have you personal knowledge? Have some of your members said that to you, that there is a preference shown to some people?

**Mr. Sarra:** A preference shown to doctors.

**Mr. Turner:** Over the individual.

**Mr. Sarra:** Over individual claims. The doctor's claim could be in at \$40,000. An individual claim might come in at \$20. In other words, the size of claims are very clear, and very easy to distinguish. My members have stated to me very clearly there is that preference given; on directions.

**Mr. Turner:** I would like to indicate a personal experience with my wife. It happened twice.



**Mr. Conway:** This is a family show.

**Mr. Turner:** That's right; no, no, I just draw it to your attention because somebody must be smiling from above. In the last six weeks my wife has visited the doctor and she has had the payment back before she's had the reports from the doctor, in less than two weeks.

**Mr. Conway:** They think she's married to the former federal finance minister.

**Mr. Turner:** That may perhaps have some influence. No, as a point of interest, I draw that to your attention.

**Mr. Sarra:** Yes, if I may comment on that. It's only at times of backlog that the preference does occur.

**Mr. Turner:** You're not suggesting there's a continual backlog?

**Mr. Sarra:** I would suggest that, yes. The extent of that continual backlog varies. A number of years ago it was the standing order that claims would be processed within four weeks. That then was moved to six weeks. I believe it's now eight weeks. There is a continual backlog, yes; the size of it varies.

**Mr. Turner:** Yet my wife's claim miraculously went through very quickly. No, seriously, though I—

**Mr. Breagh:** My definition of miracles is considerably enhanced.

**Mr. Turner:** I think, with all respect, there may be some misconception of what is going on up there.

**Mr. Sarra:** What you are talking about is really—and we accept the compliment, we do appreciate that our members are very efficient and try to do the best job possible. I think that's an illustration of it, that even though you do have budget cutbacks, even though you have cutbacks in staff—

**Mr. Turner:** That was the point I was trying to make.

**Mr. Sarra:** —at times the system works.

**Mr. Turner:** So things seem to be going reasonably well.

**Mr. Sarra:** There are times, I can assure you, that the system doesn't work though.

**Mr. Turner:** I haven't experienced that. Thank you.

**Mr. Conway:** Thank you, Mr. Chairman, for an invitation not yet extended. Two brief points, both of which are tangential, and I want to take advantage of your—

**Mr. Chairman:** Run that by me again.

**Mr. Conway:** You were short-circuited there, Mr. Chairman.

You mentioned in your brief—and I just tried to write it down, I don't think it's totally

accurate but I think it conveys the point of your quotation. You say the government, "for all its unused legislative capacity to keep doctors in the public health plan"; did you say something like that?

**Mr. Sarra:** Sounds like something I would say, yes.

**Mr. Conway:** I was just interested to explore that point, since it was in your brief, and since money is always an important aspect of quality of any health care or other system. Could you just explain what you meant by that, perhaps a little more fully than was at first apparent?

**Mr. Sarra:** I believe I was talking about the unused legislative powers to keep doctors in the system.

**Mr. Conway:** Do you have views on what those unused legislative powers might be, which you recommend for the attention of members of this committee who might be interested in such things?

**Mr. Sarra:** Very clearly, in terms of universal health care, I think all doctors in this province should be included in that.

**Mr. Conway:** To practise medicine in Ontario they should be legislated into the plan, period.

**Mr. Sarra:** Yes, very clearly so.

**Mr. Conway:** You had a second point, and you raised it in response, I think, to Mr. Turner or Mr. Breagh; it had to do with the 12 Overlea situation. That just sort of twigged in me a question, that is again a little bit off the main track here, but I would like your comment. I presume some of your membership, or a good portion of your membership, is going to be involved in the transfer to Kingston.

**Mr. Sarra:** We're hoping we don't move, yes.

**Mr. Conway:** I haven't been as involved in that aspect of it. It has been one of those long-range items that have been continuing. I have heard a report that they weren't moving; I'm not up to date on that item.

**Mr. Breagh:** It's liable to continue for several elections.

**Mr. Conway:** That's fine, Mr. Chairman, thank you.

**Mr. Chairman:** Any further questions? Thank you very much, Mr. Sarra. Do you have a copy of your brief?

**Mr. Sarra:** Yes, I do, Mr. Chairman.

**Mr. Chairman:** There are some members who have expressed an interest in getting a copy; if we could have that it would be ap-

preciated. Thank you very much, Mr. Sarra, for your appearance.

**Mr. Sarra:** Thank you for having me.

**Mr. Conway:** Unwell as you are rumoured to be, Mr. Chairman, you seem to have survived and prevailed to a certain degree.

**Mr. Chairman:** My hearing is starting to

fail me. Aside from that, I'm on the road to recovery. No, the health-care system didn't have a thing to do with it, I think I had a psychological block. I didn't want to go to Dryden so my body took care of the problem. I'm only kidding. The committee is adjourned until Monday next.

The committee adjourned at 5:06 p.m.

## SPEAKERS IN THIS ISSUE

---

Breaugh, M. (Oshawa NDP)  
Conway, S. (Renfrew North L)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Kennedy, R. D.; Acting Chairman (Mississauga South PC)  
Leluk, N. G. (York West PC)  
McClellan, R. (Bellwoods NDP)  
O'Neil, H. (Quinte L)  
Pope, A. (Cochrane South PC)  
Ramsay, R. H. (Sault Ste. Marie PC)  
Turner, J. (Peterborough PC)

### Witnesses:

Sarra, M., Political Liaison Officer, Ontario Public Service Employees' Union  
Wetherill, G., President, EHE Ottawa Limited











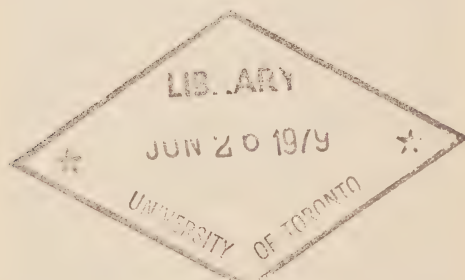
No. S-24

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Monday, June 11, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

---

MONDAY, JUNE 11, 1979

The committee met at 3:50 p.m.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

(continued)

**Mr. Chairman:** I would like to call the committee to order. Before we move into the first presentation, which will be made by the Ontario Medical Association, I would like to file with the committee some documents for their information.

The first is a copy of the presentation by the OMA. The second document is a report to the standing committee on the transfer of the inpatients from Lakeshore to Queen Street. That will be dealt with tomorrow when the minister is here. Further, I will file with the committee a letter I received from Mr. Munro with respect to the children's centre at the Lakeshore Psychiatric Hospital. There is also a background piece to that particular letter.

We have with us today, representing the Ontario Medical Association, Dr. Caldwell, Dr. Vail, Dr. Reese and Dr. Clarke. Gentlemen, would you like to begin?

**Dr. Vail:** Mr. Chairman, as a preamble to our presentation to you and the members of your committee, we should like to register the following: That every patient who now enters the Ontario hospital system is receiving good and adequate health care; that the Ontario hospital system is an exemplary one when compared to most other health-care jurisdictions. Having said that, we would like to impress upon you, sir, that the Ontario Medical Association firmly believes that the fiscal pressures being exerted upon hospital budgets are beginning to create, in numerous ways, various degrees of deterioration in the services of hospitals.

To what extent these deteriorations are occurring depends to a large extent on what hospital you are looking at. Some have already identified their concerns to this committee. Others are attempting quite courageously to cope with their problems, and still others are only affected at present in minor ways.

While such statements may appear to the committee to be too general and without statistical or other support, it must be kept

in mind that the operation of the hospital system, and of each individual hospital, is a delicate balance of a large number of inter-related activities. If you affect one, then others are also affected. What we are beginning to see is the resultant domino effect; it is difficult to put one's finger on, but perceptibly there to those who work within the hospitals.

In order for you to perceive this more fully, let us look at two analogous situations we see occurring.

**Surgery:** The amount of surgery performed in any hospital depends on the number of operating rooms, beds, both in and outpatient, and staff to look after the patients. When you cut back in any one of these areas you affect the others. Intangibles begin to creep in.

For instance, if more outpatient surgery is performed in a hospital, thereby allowing you to cut back on active-treatment beds, you may calculate a potential saving in nursing staff. However, while you may end up with fewer beds, you can be sure that the patients in those beds require greater services because of the severity of their illness.

Cutbacks in nursing staff could be detrimental to those patients. If you cut back outpatient beds you can only perform limited elective surgery per day. While that may end up as a saving to the hospital, you also end up with a lengthening list of patients waiting for surgery. Again, the patient is the one who may suffer.

**Referral patterns:** If a smaller hospital has a bed cutback it is quite certain some patients will be referred quickly to a larger metropolitan or teaching hospital. However, if that hospital also has a bed cutback it is just as certain the patient will be referred back to the smaller hospital as soon as possible and sent home as quickly as possible. Again, the hospitals are adhering to their budget limitations quite satisfactorily, but to the potential detriment and expense of the patient and his or her family.

Hopefully, through these analogous situations we have illustrated the possible deterioration in service to the patient through overzealous budget restraints. The problem for the patient is that he or she will not be aware of these problems until illness strikes. The prob-

lem for the physician or anyone else is that the frequency of the problem is totally dependent on the level of activity of the hospital when the patient requires the service.

Therefore, it is difficult to document the problem. However, such situations are occurring more often throughout the province and we are beginning to hear increased rumblings from our members. That is a bad sign.

Now we have broached the subject on a broad basis, let us attempt to be more specific.

Hospital beds: This is the area where the Ministry of Health is pursuing a course of across-the-board planning most vigorously, specifically where active-treatment beds are concerned. The central question, of course, is: Does the 3.5 guideline pose an essential problem to the hospital system in this province? Frankly, we don't know. However, just as frankly we don't think the Ministry of Health knows either.

At the same time, we know that every hospital, in order to service the community, must have a reserve of beds. Occupancy of 90 per cent is the upper limit of sensible and safe hospital management. In obstetrics, the limit is 80 per cent. Therefore, occupancy rates can only be a guiding factor, not a determining factor.

[4:00]

Furthermore, the problem for every hospital is that you cannot mix cases. There must be designated wards for the different services. For instance, you cannot have a surgical patient with a freshly lanced abscess bed-spaced to the maternity ward. Therefore, the approximate mix within hospitals must be maintained. In addition, the bed needs of any hospital are not constant, but continually peak and fall. If beds are trimmed to meet the average daily census, then every time a peak occurs there is a crisis situation within the hospital with the resultant inconvenience and suffering by the patient.

We agree that planning is required in order that health-care costs do not gallop out of sight. However, we do not think that precise, statistically-based planning in any way resolves the problem.

The Ministry of Health has put great emphasis on the work of district health councils and we, as an association, applaud the sincerity, energy and enthusiasm of the voluntary members of these councils. However, it should be remembered that the councils are the offspring of the ministry itself. We do not say that there is collusion or coercion in the relationships between the

ministry and the councils. But we know that the ministry through its staff has a great deal of input into the councils, provides backup support through staff personnel and funds their research.

What concerns us is the extent of the influence of the ministry. Does the ministry applaud the efforts of the councils—and it does this frequently—only when those efforts coincide with ministry aims? Are grants awarded only when the terms of reference are in line with ministry objectives? How enthusiastic is the ministry in communicating with the councils on ways of restraining costs versus ways of improving health-care facilities through additional expenditures? These are some of the questions that plague us in the medical profession and, we feel, are ones that should interest this committee.

The problem of declining morale, we feel, is an increasing one in Ontario hospitals and it affects all professional staff. The ability of physicians to practise their profession within a hospital to recognized standards is undermining morale and is based directly on the lack of funds. This same situation is occurring to the nursing and technical staff for the same reasons.

Nurses tell us that their work load is getting heavier. This leads inevitably to fatigue and low morale. Nursing hours have decreased in hospital budgets. Nurses genuinely feel they are being badly stretched. Such a situation, if left to continue, can cause grave dislocations of highly-trained nursing staff.

Replacing old equipment and acquiring new diagnostic and therapeutic equipment is a costly area and one that we feel has not been handled well by the ministry to date. We commend the ministry for its reasonable position on diagnostic ultrasound—a position only recently taken—but criticize it strongly for its failure to provide CAT head scanners for all neurological centres. The OMA suggests that the ministry cease planning for new technology in isolation. It should consult with outside experts from the outset to decide what is medically necessary in this province. Then government can state exactly what it can afford.

In conclusion, we feel our role here today is one of being a resource to your committee in its deliberations. Our presentation has attempted to capsuleize the dilemma now occurring in hospitals and to point out those areas in which we feel immediate concern. We strongly feel that there must be an appeal mechanism for hospitals which suffer under restrictive budgets so that fair evaluation and redress can be made. We can



assure the committee that the medical profession will continue to exercise its watchdog role toward all aspects of health-care delivery within the province.

We have no quarrel with government, as we said earlier, attempting to control potential runaway costs within the hospital system, but we are gravely concerned that it is fast approaching a situation in which clinical brinkmanship is coming into play. Such a situation cannot be condoned to the possible jeopardy of the patients.

That concludes our more formal presentation, but obviously my colleagues and myself are quite available for any questionings.

**Mr. Chairman:** Dr. Reese, do you have anything to add?

**Dr. Reese:** Recently in London, which is the Thames Valley District Health Council area, they have just completed a study, *The Planning for Acute-Care Services*, which was really a response to whether the 3.5 beds per thousand ratio was applicable to the London Hospital Centre, which is a tertiary care referral area. I have taken the liberty of extracting some sheets from that and it might be better if the committee members had these in front of them. I would like to refer to some of these, as some of these are numbers and numbers don't speak well.

In the statement they made about teaching hospitals they say the bed formula makes no special adjustment for teaching hospitals which provide more specialized tertiary care, generally have longer lengths of stay and receive large numbers of referrals from non-teaching hospitals. The ministry recognizes this deficiency. However, at present there is no indication of any changes which may be introduced in the bed formula to account for these differences in active-bed utilization.

As you may or may not be aware, if you want to skip to the sixth sheet, the method that is used is the so-called separation which means a discharge from the hospital, taking into account the actual number of days rendered by the different hospitals in the region to those individuals. If you want to go through those numbers with me, I think it would be instructive.

Let us take an area of 40,000 people where the local hospital admits all its patients from its area for 7.4 days, which is a low average length of stay, and refers half to the regional hospitals where they stay an average of 11 days because these are the longer stays. For example, a patient in a small hospital might come in for a routine, uncomplicated, hernia operation, whereas if he has severe heart disease he will be sent

into a tertiary hospital where the medical people will put him into good shape first and maybe implant an \$1,800-pacemaker in him before he can safely have his anaesthetic. Then he ends up spending two weeks there for the same operation.

Assuming that if 3,200 patients were looked after by the local hospital and 1,600 sent to the regional hospital, then that makes a total of 4,800 separations. The result is the local hospital would get credit for looking after two thirds of that population and the regional hospital for one third.

At the 3.5 bed ratio, the 40,000 population would equate to 140 beds. They would be split between 93 beds in the community hospital and 47 beds at the regional hospital to service that outlying community. Because of the differences in stay, it would mean that when you make the occupancy rate for those beds, it would be about 70 per cent in the small hospital and 104 per cent in the teaching hospital. This then results in putting pressure on those beds for the community needs in the community in which the tertiary hospital is placed, whereas if you apportion them according to the number of days spent by those patients in the two types of hospitals, you would end up with an 81 per cent occupancy in the community hospital and 82 in the regional hospital, or roughly in the same ballpark.

The following two pages are of interest. They come from University Hospital in London. They have an average per-day rate of \$300. But, as you can see from that sheet, the medical patient costs \$250 a day; a general surgical patient, \$637; an orthopaedic patient, \$862; neurosurgery, \$1,200; and cardiovascular surgery, \$1,300. You can see it makes quite a big difference as to what type of patient you're looking after.

In the next to the last sheet is what has happened to things like heart valves, pacemakers and the hip implants. In 1977, the heart valves were \$525. They had two price increases in 1978, and by 1979 they were \$930. The pacemakers used to range from \$1,295 to \$1,895, depending on the type being used, and they're now \$1,750 to \$2,495 for the same types. The hip implant started at \$265 and went up to \$530. They will probably be shifting to a new type of implant that will cost twice that again—a 400 per cent increase in the cost of that implant. The ages you see there are just the average age of the patients receiving these types of prostheses.

The last sheet is sort of a summary of the conclusions by Peat Marwick, the consultants. Their review of the Ontario Ministry of

Health's new bed-allocation formula, as applied to the Thames Valley district, has indicated a reasonable approach to the proposed allocation of active-treatment beds to the district.

At the same time, we have pointed out some of the weaknesses in the formula: namely, the use of separations versus patient days to determine referral patterns does not accurately reflect the true utilization patterns.

Two: lack of special consideration for teaching hospitals ignores the importance of tertiary care and the impact of education and research programs on bed utilization.

Three: no consideration for possible interactions among the hospitals in the district leads to inaccurate conclusions.

Four: hospital physical facilities are not considered in the allocation.

Five: non-resident beds have not been included in the allocations.

Six: no consideration for the availability of other services, such as chronic care, ambulatory care, nursing home beds, homes for the aged, et cetera.

Our own hospital, for example, will be short about \$2 million. They would have to close in excess of 100 beds in order to try to live within that budget. The Catch-22 is that, for every bed you close, you lose \$12,000 from your budget, so you don't gain very much by closing beds only.

**Mr. McClellan:** Which hospital is it, University Hospital in London that's short \$2 million?

**Dr. Reese:** No, that's St. Joseph's Hospital in London.

**Mr. Chairman:** Dr. Clarke, do you care to make any comments?

**Dr. Clarke:** No.

**Mr. Chairman:** Mr. Breaugh? I should tell the members that we have four presentations this afternoon. Because of the length of question period and, more accurately, what preceded question period today, we are a little late in getting started. So if the committee would agree to allocate 30 minutes to each presentation, I think we could be completed by six o'clock. If you'd agree to do that. Agreed?

**Mr. Breaugh:** I think we might be prepared to try. First of all, I want to commend the OMA for making this presentation here this afternoon. I must say, as one who represents a party that has, on occasion, been referred to as doctor bashers, let me correct the record on that one and say that at least this afternoon we're going to pat you on the back. It's precisely the kind of information

we have been trying to get. In my view it was a most concise and accurate, in fact dead on, presentation in summary form of the problems we're after. It's indeed refreshing to see a body like OMA do exactly that.

I want to go through very quickly the points you have raised, I think they're almost a précis of what most of us have been grasping at for the last six or eight months.

In the first one, where you dealt with the bed formula, your comment is that you don't think that a precise, statistically-based planning process in any way resolves the problem. That's precisely our point of view as well. Someone who worked for the ministry appeared before us last week to say much the same thing. How did a guideline become a hard and fast standard? Were you involved in that process at all?

**Dr. Vail:** Not to my knowledge, Mr. Chairman. It was a figure I think they pulled out of the hat, and I'm not quite sure what hat they pulled it out of.

**Mr. Breaugh:** At any rate, you weren't there holding the hat.

**Dr. Vail:** No, sir.

**Mr. Breaugh:** Thank you. Your comments on district health councils: Extremely pertinent, particularly the part where you reiterate that what concerns you is the extent of the influence of the ministry. Is it true, in your experience, that a distinct health council is virtually hide-bound—appointed, in the first instance, and dependent upon funding, in the second instance, for almost everything that it does?

**Dr. Vail:** The problem, I guess to be fair and to be honest, is that there are various capabilities of various health councils, and it's very difficult to sweep them with one big brush. We've expressed to you, Mr. Chairman, our concerns about district health councils. I suppose one can always pick out a district health council which is exemplary and does not follow that description. But these are our concerns, and we've placed them here.

I think there are other concerns we have, too. As a matter of brevity we didn't include them. We're concerned about another level of bureaucracy between Queen's Park and the hospital, or whatever the institution is. We're concerned that it may be a method of stopping the political end run, something that you gentlemen no doubt recognize. And maybe the end run still goes on, even though the health council is in place. We've been concerned, as we expressed here, that the health councils more often agree with what the ministry wants, rather than maybe looking



for extra costs, which they may well need in their areas.

[4:15]

**Mr. Conway:** If I may put a supplementary point, very briefly, on that, Mr. Chairman. One of the areas where the health councils are subjected to considerable criticism, if my experience is any guide, is to the method of appointment. One of my colleagues was outlining a case in his particular region which sounded bizarre, to say the least. Is it the impression of the medical community that the appointment process to the district health council is not as useful as it might be? That indeed, there seems to be a strange method sometimes employed to get people on, at a great length of time?

**Dr. Vail:** To be honest again, we feel that a doctor's position on the health council is an important one. One thing I think is important, and I'm expressing a personal view, is that hospital administrators, for instance, are not permitted to sit. I would think they're probably the professional people with the broadest and greatest range of health care within their community. It seems incongruous that that would occur.

**Mr. Pope:** A supplementary, Mr. Conway: Surely you can visualize the reasons why hospital administrators might not be on. Surely you can visualize that where a district health council has to make some sort of recommendation to the minister with respect to allocations of certain types of beds between two different hospitals it might be a problem.

**Mr. R. F. Johnston:** Board members are on.

**Mr. Pope:** We're talking about hospital administrators. Do you not feel there is some reason? And surely you'd also admit that there's some controversy as to whether or not medical practitioners should be on, as well.

**Dr. Vail:** I agree with all those, and of course you're referring to conflict of interest. I always have the hope in human nature that people who hold responsible positions are able to rise above those occasions, especially when they're in the public forum.

**Mr. Breaugh:** The third point that you made was about nurses genuinely feeling that their services are badly stretched and if that situation is left to continue it can cause, to use your words, grave dislocations of highly trained nursing staff. Does that same comment or observation apply to other practitioners in the medical field, people other than nurses?

**Dr. Vail:** I wonder if I could just pass that to my colleague, Dr. Clarke.

**Dr. Clarke:** The statement begins with "nurses tell us." They did tell us; that's a direct quote from the chairman of the Ontario Nurses Association. The last sentence is our own, and I'll tell you my own personal experience. I left my practice, 12 years of clinical neurology, because of the situation. I chose to stay in Canada and go into administrative medicine. Three of my mates on the internal medical staff have left for the United States. Of the total of 12, four have gone in a year and a half.

**Mr. Breaugh:** In the hearings we've had to date we've heard from virtually everyone, from hospital workers who clean the floors, to—in private conversation—technicians running machines, nurses themselves and even doctors, all coming to much the same conclusion. Would you say that there is now a consensus in the entire field of medical practitioners of all types and sorts, that we are too close to the borderline, to put it politely, and well past it, according to other sources, in the matter of cutting back? Would you say the measure of safety is no longer there and that we have crossed whatever kind of threshold should have been established?

**Dr. Clarke:** This is very hard to say, as the presentation brings out. We don't know that the 3.5 guideline is critical where we are, except that in the last two years at least, if not three years, there are trends happening. We're hearing stories from all over the province. The cynic would say, "Well, what good is an anecdote?" A single anecdote, yes, but hundreds of anecdotes add up to something.

**Mr. Breaugh:** The fourth point you raised was on technology. You raised the sensitive point that, to use your words, you're suggesting that the ministry cease planning for new technology in isolation. We have spent some time trying to determine whether it's possible for a group of experts, whether that be the OMA or everyone else who is involved in it, an outside agency or whoever, to be making the decision about—to use your words again—what is medically necessary in this province—if that kind of a design model ought to be put together and that outside reference group ought to be implemented. Can you suggest a model for us? Who should be on this?

**Dr. Clarke:** I think an OMA representative committee, or a very small group of individuals, could meet on a continuing basis with the Ministry of Health officials. Together they could state what is medically necessary, for this province.



I think the CAT scanners, these wondrous new X-rays for soft tissue, are a perfect example of this process. The OMA would really have to bite the bullet here, too, to resist pressures from all its members, because every hospital would love one. Region by region how many does Ontario need? With the ministry, could they come up with a sensible figure? Then government too say, "Okay, we'll take that. Now here's what that costs. Here is all we can afford now." The third step is once again the consultative role of deciding, Okay, it falls short, but it's the best you can do at the time. Here's where they should go."

This has not happened, to date. Unfortunately, groups of highly trained professionals are told, "You don't need this." What they are really saying is, "We can't afford it," but from an isolation point of view, they are told, "You don't need it." Well, nothing strikes anger like a statement like that.

**Mr. Breagh:** To put what I suppose might be considered by some an extreme case, I have been told privately by administrators—and to use your example again of the CAT scanner—that the offer was put to a region in Ontario that "You get a scanner." Their response was, "We'd like to have one, but that is not our priority." The response once again was, "That's what we're offering, a CAT scanner. You may argue about who gets it, and to which hospital it goes, but we're not prepared to listen to your local priorities."

To reverse the coin on that, I know of at least one other area where everybody has agreed locally that the CAT scanner is the necessary piece of equipment. The mechanics of getting approval for purchase of the unit and putting it in place in the hospital, although it was decided I believe about nine to 12 months ago that that should happen, the approval process is such that it still has not happened.

Is that generally a consensus of what's happening in Ontario? That you are told who will get what, and where it will go? That you may decide locally into which hospital it will go, but the piece of equipment is decided centrally?

**Dr. Clarke:** The approval, the dollars, that's a central decision.

**Mr. Breagh:** Dollars?

**Dr. Clarke:** It's a dollar argument, basically.

**Mr. Breagh:** I understand that we have a little hurry on this afternoon but I would like to take a couple of minutes more.

You feel very strongly that an appeal mechanism for hospitals should be put in place. It's my point of view, and we discussed it quite a bit in this committee, that that appeal mechanism should indeed be put in place. What's more, it should be a very open mechanism. It should not be an in-house thing. This seems to be somewhat at odds with the position put to the committee by the Ontario Hospital Association, which seems to believe there is an appeal mechanism. It's called "go visit the minister." Could you elaborate somewhat on what you might consider to be an appropriate appeal mechanism?

**Dr. Clarke:** Do you want to take that one, Will?

**Dr. Vail:** Certainly. It would appear to me that if a hospital with its individual problems, should be able—and I agree with you—to in some degree in a public forum make a statement to the minister—because that's where it has to go; that's where the decision has to be made—and for that to be acted upon rather expeditiously, either yes or no. The decision should not be prolonged, with a request for more studies and the argument carried forward for time immemorial. Rather it should get a decision and get it rather promptly, then it will go back to the public and the public in that community will use whatever influence it can if the decision is unfavourable, or doesn't appear to be fair.

**Mr. Breagh:** So in your view, as an association, it wouldn't be impossible to establish an appeal mechanism like we do for the compensation boards, or for disability pensions, or for planning decisions, or for the multitude of other appeal boards that are out there? It wouldn't be an impossible task, then, to set up an appeal mechanism at which local doctors could appear? This includes the local public who are footing the bill, they could appear; hospital administrators could appear. The ministry obviously could be there. Such a body operating in the public milieu, so that everybody knows what's going on, would be a quite possible and practical solution to some of these problems.

**Dr. Vail:** I see no reason for any problem, and again, as long as some action is taken rather quickly upon whatever the ministry's opinion is in that regard.

**Mr. Breagh:** I take it you would define action as being something a little bit more than setting up a conference for small hospitals, some time in the fall.

**Dr. Vail:** The answer is usually "yes," "no," or something in between.

**Mr. Breagh:** You closed with a comment which disturbs me somewhat. It disturbs me because I've heard it not only from you, but from several administrators across Ontario in private, and a few in public before this committee. You say you've gravely concerned that it is fast approaching a situation in which clinical brinksmanship is coming into play. Would you care to elaborate on that somewhat?

**Dr. Vail:** Certainly. We have great concerns that our physicians are under pressures of availability, and that they may well be delaying admitting patients, or discharging patients too soon. They may not be using equipment that is up to date and effective. We can quote you examples where some of the equipment is very important equipment, but it's questionable whether it's effective and efficient. These are the kind of examples we call "clinical brinksmanship," or "clinical judgement." It is sometimes pretty risky. We don't think that's fair to either our profession or to the public.

**Mr. Breagh:** The problem we have with all of this, of course, is that under the current situation we, as members of the Legislature, are sitting back, having to wait, and almost be silenced by some coroner's jury making a decision, or an appeal before a Supreme Court judge. It is the absence of what might be seen as a third party, not directly interested in the dispute, but giving expert testimony to members of this committee and providing them with that kind of specific example.

We hear from Meaford that a severe hazard is going to be present next year in that area because of the withdrawal of certain financial support systems. We've heard you say it again, today. It would be of more than passing interest for the members of this committee to be able to document, "Are there really problems?" because who can judge whether a back-up in elective surgery in Etobicoke constitutes a hazard or an inconvenience? It's that decision that's very difficult for us to make.

Could I move to a presentation made, I believe, by Dr. Reese from London? First of all, could I ask you to take up that study with the members of the committee? Could we get copies of that? Would that be possible?

**Dr. Reese:** I Xeroxed some excerpts from this. This was released on May 17 by Thames Valley DHC to the three hospitals in the area. I suppose we can request Thames Valley to release it to you, but I can't very well release a total document to you.

**Mr. Breagh:** Okay. I think the clerk of the committee might get in contact with the Thames Valley District Health Council, to ask that copies be made available. All right?

Could I ask that you make some comments, then, on the specifics you presented to the committee? In particular, I'm interested in the formula that's used here. That item you're referring to as a separation method. You're really, in a nutshell, saying that the short end of the stick in that separation process goes to tertiary care units. Could you be a little more specific? This is, I think, a good analysis of it. Could you relate that a little more directly to, say, the teaching hospital as opposed to a smaller hospital?

**Dr. Reese:** If you look at exhibit two, for example, which is the fourth sheet, which relates only to medical-surgical utilization, and the three teaching hospitals, University, Victoria and St. Joseph's are at the bottom, you will note there the occupancy rates of 92, 82 and 93. Then in exhibit number four particularly, obstetrics, which is in the next sheet, St. Joseph's is running at 95 per cent occupancy, which is a dangerous occupancy rate for obstetrics.

St. Joseph's happens to be the regional, high-risk obstetrical unit for southwestern Ontario. That is the reason why we get obstetrical cases out of proportion to our local, normal catchment area.

You will see two things there; one is a relatively low, 5.8 day, average stay, with a 95 per cent occupancy. This comes about because some of these high-risk patients might spend their last six weeks or two months of their pregnancy in our hospital. But some of our local patients coming in for obstetrics may be getting turfed out on their third day, post partum, because we need the bed.

[4:30]

The same thing goes for our surgery. Even though we are also doing tertiary referral work for the area, although not to the same extent as the University Hospital, our stays are 8.5 versus 10.8 for Victoria and 11.2 for the University Hospital. What happens again is that our patients may go home on the third or fourth post-operative day, as opposed to six or seven days, which is considered more normal.

This becomes a clinical judgement, an order to "Take that catheter out, send him home." "Stop that IV, send her home. She'll probably be all right." But some of them come back to emergency that night again. So we're forced into moving the patients faster in order to continue to do the work.



I think it's essential for the committee to understand that patients are referred to doctors and that the doctors will service these patients in the hospital in which they have privileges, and therefore it's no good to know that down the road, as in Tillsonburg, their obstetrical unit only has 24 per cent occupancy and therefore you can get all sorts of obstetrics done there. The obstetricians are working in London and the people who live in Tillsonburg prefer to go to an obstetrician who happens to work in London, rather than to be delivered locally and these are facts of life that have to be accepted.

**Mr. Breaugh:** Could you just explain to me, on exhibit two it appears to me that four of the nine hospitals you've named here are—and I'm searching for words—over an acceptable limit of occupancy and that probably two or three more are extremely close to that. Only one or two are within safe levels, in terms of occupancy—is that right?

**Dr. Reese:** Yes, for medical-surgical up to 90 per cent is considered a safe occupancy level. You have to appreciate that patients do not come into the hospital on a Friday for surgery on Monday. If Monday's a holiday you find a ward such as mine, urology, which is a very active ward and always full, might be only at 50 per cent occupancy on the Saturday, because there's no sense bringing in patients on a Friday or Saturday or Sunday. They don't come in until the Monday.

This is why you can never have absolute occupancy, because hospitals basically still work five days a week. The laboratories don't work on Saturday and Sunday; the X-ray only has skeleton crew; and to try to make the hospitals function on a seven-day week is impossible, because people want to have their weekend off. You can't get staff to work. It's preferable to run a department at a high level of efficiency five days a week and have emergencies only on Saturday and Sunday, than to try to work seven days a week and not be able to get good staff because they don't want to work weekends.

**Mr. R. F. Johnston:** Just as a supplementary to that, what is the significance of January 1 being taken as the day on which this was established? It seemed to me from what you're saying that would be a low day.

**Dr. Reese:** No, bed staff means hospitals have a set number of beds which have been allocated to them, okay? But not all hospitals necessarily had all of these beds staffed.

**Mr. Breaugh:** Was that before the bed cuts were made?

**Dr. Reese:** This is before the bed cuts, yes. The bed cuts started on April 1.

**Mr. Breaugh:** Could I just run down the conclusions and end on those?

**Mr. Chairman:** I should remind you of the time, Mr. Breaugh. We're into a time jam already.

**Mr. Breaugh:** I appreciate your problem, Mr. Chairman, and I also appreciate that I last week sat and listened patiently to consultants in use by the ministry and I've finally gotten somebody before this committee with the credentials to testify and I've got some questions I just can't pass up. I'll make them as brief as possible. The conclusions that you came to—

**Dr. Clarke:** I'd just like one little comment on the statement about bed allocations. The ministry will allocate so many beds and what that statement shows is beds staffed. Beds staffed are what monies the hospital gets to operate beds. It bears no relation to the figure of bed allocations; there's a gap between these two figures. If you hear that a hospital is allocated for 400 beds, they sure are not running 400 beds. They can't afford 400 beds. It would be more like 375, 360—something like that.

**Mr. Breaugh:** I want to just move quickly then and wrap up with the conclusions you put before us. I recognize that this is for one district health council, but it strikes me they're certainly applicable to every one I've ever seen.

In the initial paragraph you do what I think any reasonable group of people, or consultants, or whoever, would do on that issue. You recognize that some reason has been exercised. But I must say the six points you raise are pretty hard-hitting and pretty fundamental: That the use of separations versus patient days does not accurately reflect the true utilization patterns; that the lack of special consideration for teaching hospitals ignores the importance of tertiary care; that no consideration for possible interactions among the hospitals in the district leads to an accurate conclusion; that hospital facilities are not considered in the allocation; that non-resident beds have not been included in the allocations; and that no consideration for the availability of other services, such as chronic care, ambulatory care and nursing home beds, homes for the aged, et cetera.

It strikes me that those are rather serious. I'd put forward more than the word "considerations." That strikes at the heart of the problem this committee is discussing on six very basic points and you are not mincing your words at all in this study.



It strikes me as a pretty severe condemnation. I am offering you the opportunity to soften it up, if you care to. I am not encouraging you to.

**Dr. Vail:** No, I think first of all, as an independent survey or study, I suppose it's like all studies, it's open to criticism and it'll be criticized, but it speaks for itself and that's all we can say.

**Mr. Breagh:** I thank you for a most forthright presentation, very refreshing.

**Mr. Chairman:** Thank you, Mr. Breagh. Mr. Pope.

**Mr. Pope:** Thank you very much, Mr. Chairman. Does the Ontario Medical Association meet on a regular basis with the minister?

**Dr. Vail:** Yes, almost on a monthly basis, like 10 or 11.

**Mr. Pope:** During the course of the meetings over the last year, have you discussed with the minister or raised the subject of hospital budgets and bed ratios and allocation formulas, this kind of thing?

**Dr. Vail:** I don't think we went into as much detail as we have today, but we have indicated publicly through the officers of our association on many occasions our great concerns in these areas.

**Mr. Pope:** Right. Why wouldn't you have gone into it in as much detail with the minister as you have today?

**Dr. Vail:** There are two or three points that I'd bring forward. First of all, our meetings with the minister are often what we call housekeeping meetings. In other words, they are problems and situations we have discussed with him. There are other members of our staff within the association who are discussing certain of these problems with other members of his staff. More recently, we have been concerned primarily with the subject of new technology and that has been discussed with him. I think we may have been negligent in this area, but we felt the Ontario Hospital Association was within its realm of expertise and authority and in some cases I suppose we have delegated that responsibility to them.

**Mr. Pope:** So you are really not telling this committee there has been no communication between yourself and the minister on some of these problems?

**Dr. Vail:** No.

**Mr. Pope:** You are just saying you haven't given him as complete a presentation as you have given to this committee today.

**Dr. Vail:** These are all public facts, so there is nothing being revealed here that is secret.

**Mr. Pope:** I am sure several individual members of the profession have written letters to the minister.

**Dr. Vail:** I don't think he is unaware of our concerns.

**Mr. Kennedy:** As a supplementary, why wouldn't it be a very high priority of the OMA to discuss this subject, which is really the total content of your brief, with the thrust towards budget? I don't understand this.

**Dr. Vail:** I think you misinterpreted me. The first thing is that these matters have been discussed publicly.

**Mr. Kennedy:** Publicly is one thing. It was discussed through the press.

**Mr. Breagh:** There should have been privacy in all of this!

**Mr. Kennedy:** It seems to me that a reasonable thing to do would be to go to the partnership in medical care and take this up with them.

Interjections.

**Mr. Kennedy:** What's funny about that?

**Mr. Pope:** Perhaps they've given up on them, then they can say that; then they would have some comments on that attitude as well.

**Mr. Kennedy:** I don't know what the big laugh is all about over there.

**Mr. McClellan:** Carry on, you are doing well.

**Mr. Pope:** I'd like to echo Mr. Breagh's call that this full study be documented, because the conclusion is that the review of the Ontario Ministry of Health's new bed allocation formula, as applied to the Thames Valley district, has indicated a reasonable approach to the proposed allocation of active-treatment beds to the district.

So I agree with my friend. I would like to see the entire document before the committee and I would urge you, Mr. Chairman, to actively seek out the production of that document, because some of the highlights and some of the extracts and some of the figures that have been set out here make me wonder about this conclusion.

There seems to be some questioning on the part of the Ontario Medical Association as to the referral population system of hospital allocation. I am trying to understand the thrust of your presentation. Are you disagreeing with the referral population system, or are you saying that something in

addition, such as occupancy rates, should be taken into consideration? Or would you rather have length of stay as the test?

**Dr. Reese:** The problem with a separation is that a simple case might be in hospital six days.

**Mr. Pope:** Yes.

**Dr. Reese:** A complicated case which goes to a tertiary hospital will be there for two or three weeks. Therefore, if you do it on the basis of discharges of patients from that area, which is what separations mean, you are short-changed if you are looking after the complicated cases. So you have to take occupancy into account. In other words, average length of stay.

**Mr. Pope:** Yes. The average length of stay you think should be folded into the occupancy—

**Dr. Reese:** It has to be folded in.

**Mr. Pope:** It has to be folded into the occupancy rate to arrive at a truer formula. Should this be applied only for regional centres, hospital centres? Or should it be applied for all hospitals?

**Dr. Reese:** It should be applied on the basis of the mix of cases they have.

I don't want to leave you with the impression that only teaching hospitals are faced with this problem. There are levels of hospitals. There is the small community hospital which only handles so much—you might call it first-echelon care. Then you have more complicated cases, which will go to larger hospitals, some of them teaching, some of them not. Finally you have the extremely complicated situations which invariably end up in the teaching hospitals, so for that type of hospital you have to take into account the length of stay, as well as the separations.

Other things complicate matters in a small community that has no chronic beds. They cannot get rid of their acute admissions either, so they may have long stays. The reason they have the long stays is because there is no place to send that patient. This is why the interaction between acute hospitals, chronic hospitals, nursing homes, homes for the aged, has to be taken into consideration.

**Mr. Pope:** So, in some instances then, a conversion of active to chronic would be in order?

**Dr. Reese:** Yes, I think that would be true.

**Mr. Pope:** What factors do you think should be applied in determining the numbers of conversions? Would it be again a

length of stay, or would it be just the clinical diagnosis of chronic versus active?

**Dr. Reese:** For example, you have a patient with a stroke. After that patient is stable he doesn't have to stay in an acute hospital, but he might still need hospitalization for many months. That's the type of patient who goes to the chronic hospital. And I am sure Dr. Clarke, as a neurologist, could amplify it.

**Dr. Clarke:** That's correct. You have a patient, he's confused, he's got a catheter in, no nurses to spare the time—

**Dr. Reese:** A nursing home won't take him; no one else will take him; they can't go home or anything.

**Dr. Clarke:** They'll sit for three months waiting for a place in the chronic hospital and then it's our fault for plugging up an active-treatment bed.

This is the big problem. I don't know the solution to it, but cutting beds from an active-treatment hospital is not the answer. It has that many fewer active-treatment beds; there are still stroke patients going to be there, you can't send them home in a taxi.

**Mr. Breaugh:** It's the only game in town.

**Dr. Clarke:** So we are the only place that can look after them, other than another active-treatment hospital.

**Mr. Pope:** Then you feel the answer would be to have more chronic-care beds?

**Dr. Clarke:** If available, right.

**Mr. Pope:** If, as according to some criteria, there might be an excess of active-treatment beds, you'd be in favour of converting them to chronic?

**Dr. Clarke:** In that hospital?

**Mr. Pope:** Yes.

**Dr. Clarke:** Yes.

**Mr. Pope:** Okay. I wanted to get back to a point that was raised about the London-Tillsonburg situation. I think it related to lengths of stay again.

You pointed out a table in the part of the report you produced for us. You don't think that the determination of the length of stay at the London hospital—you termed it the medical judgement—that you're not putting forward a case there is some danger to the patient from a discharge out of the London hospital after an average of eight and a half days? I think you used the three or four days after birth example, as opposed to six.

[4:45]

**Dr. Reese:** In a sense you're opening up Pandora's box, because it's a very complex

thing. Let me try to take you through a couple of examples.

A patient gets admitted to a peripheral hospital because he can't pass his water. They might keep him there two or three days and then decide that he needs surgery at one of the hospitals in London. He then gets separated from that hospital and is admitted to one of our hospitals where he stays the normal length of time for that particular situation.

They were thinking of doing the patient's hernia there, but because of his heart status the anaesthetist does not wish to give him an anaesthetic. So they load him off to the tertiary hospital where they have better facilities to look after him. But they may have had him there for three or four days before they make this election. When they take their average lengths of stay, it takes these two- and three-day admissions, plus their usual nine- or 10-day ones and they end up with seven days.

We're getting the toughies. We end up with the longer stays if we have the beds. This is why, at the University Hospital it's 11.2 days and at the Victoria Hospital it's 10-point-something. It went down to 8.5 because for the number of patients we service in our hospital we don't have sufficient beds, so you move them faster.

**Mr. Pope:** Where do you move them to?

**Dr. Reese:** Home—home care.

**Mr. Pope:** But are you saying this is a danger to the patient's safety?

**Dr. Reese:** For me to say it was a danger would be to say that I have used the wrong clinical judgement in sending him home. I use the best possible clinical judgement in sending him home, although I know I am sending him home a day or two earlier than I normally would.

From the point of the view of the patient, it means that he leaves his bed that morning, goes home, gets into trouble, and comes back to emergency that night. We have no bed for him, so he spends the next two days in emergency on a stretcher. Now, if you were the patient, you might feel hard-pressed for having been sent home.

**Mr. Pope:** Would you, as a normal practice refer patients back from London Hospital Centre to the referring hospital for post-operative recovery?

**Dr. Reese:** The ones who require prolonged post-operative care, yes. But those who need normal post-operative care, no, because you get involved with the pure legality and morality of the obligation to your patient. You've operated on him; you are morally and legally

bound to give him the normal post-operative care. You cannot discharge your responsibility by shifting him out. Now if a patient, as an example, gets a stroke or a coronary after his surgery and you no longer have anything active to offer him and he can be looked after back in his own community, yes, you would send him back.

**Mr. Pope:** You had an example of occupancies, I think, in the obstetrics wards. You mentioned 95 per cent in London, and 24 per cent in Tillsonburg. You had some concern about the 95 per cent being excessive. I think your guideline in your brief is 90 per cent.

**Dr. Reese:** No, 80 per cent is the guide for obstetrical units.

**Mr. Pope:** It's 90 per cent for surgery, 80 for obstetrics, okay.

What would you say the answer is in terms of the Tillsonburg Hospital with a 24 per cent occupancy?

**Dr. Reese:** I think the answer is an obvious one. They have too many obstetrical beds for the amount of obstetrics they do.

**Mr. Pope:** You see, this gets into one of the problems we have been trying to deal with. That is how you deal with some of the concerns of the small hospitals vis-à-vis what we see as the evolving regional centralization of medical treatment. I don't know where that leads us in terms of providing available service.

How many beds are in the Tillsonburg obstetrical unit, would you know?

**Dr. Reese:** It would be in that exhibit four, I think. Twenty-two beds.

**Mr. Pope:** That would be 22 beds, and if it is 24 per cent occupancy, I guess that is—

**Dr. Reese:** They could probably drop to 10 beds and still be more than able to handle all the obstetrics they obviously do.

**Dr. Clarke:** I would think that has probably been an ongoing situation at Tillsonburg. I doubt that they have nursing staff there nursing those 24 beds. They probably have nurses to look after eight to 10 beds. The beds, I am sure, take up one whole end of the ward. The bedspread is on, the door is closed. They are not using them. I don't know that for sure, but I know in other circumstances that's what happens. The overbedding seems to be in paediatrics in some hospitals and in obstetrics in other hospitals. That's where you get low percentages showing up sometimes.

**Dr. Reese:** Just to finish that question. Dr. Clarke is quite correct that that hospital would not have sufficient staff to look after



24 beds when they have only eight to 10 patients in there. But what does happen is that when you apply this 3.5 formula, these beds which are in a vacuum—not being used—are being gobbled up and this results in a lesser number of beds where they are needed, because that's where the action is, where the patients are.

**Mr. Pope:** But doesn't the referral population system take account of this? I gather you are saying—

**Dr. Reese:** Not by separation, I keep telling you.

**Mr. Pope:** Why not?

**Dr. Reese:** Because there are only 365 days in a year.

**Mr. Pope:** Right.

**Dr. Reese:** So each bed, at 100 per cent occupancy, represents 365 days. Now, if you put patients in there for 36 days, you can only get 10 patients into that bed in a year. If, on the other hand, you only give them three days, we can put in 120. Okay? Does that answer the question as to the difference between separations and bed-stay?

**Mr. Pope:** No.

**Dr. Reese:** No?

**Mr. Pope:** No. I mean, you are still having referrals into the hospital, and you are saying those referrals are not taken account of by the ministry?

**Dr. Reese:** No, no, the referral is the separation. One patient comes in; from the point of view of the number of these you can service, it depends on how many days they occupy that bed, because you can't stack them two to a bed.

**Mr. Pope:** So you are saying that the length of stay, rather than the referral population system, should be used?

**Dr. Reese:** No, I say a combination of both.

**Mr. Pope:** Right. And have you put this to the minister?

**Dr. Reese:** The ministry understand this problem, but they are not prepared to budge at this point in time.

**Mr. Pope:** Have you put this to the ministry?

**Dr. Reese:** Me personally? No.

**Mr. Pope:** Has the Ontario Medical Association?

**Dr. Vail:** To my knowledge, that particular area hasn't been discussed. In fact this is new information, as far as I am concerned.

**Mr. Pope:** Okay. I want a couple of clarifications on your brief. At the bottom of page three and at the top of page four: are you talking about the cushion which relates to the 80 per cent obstetrics, and 90 per cent surgical? Or are you talking about a cushion on top of that?

**Dr. Vail:** We are talking about a cushion overall. Is that what you are asking?

**Mr. Pope:** Yes.

**Dr. Vail:** What we are basically saying is that they are not constant. For some of the reasons Dr. Reese has pointed out to you—you know, weekends—there are all kinds of reasons why hospital can't work in a constant fashion. This is to what we are referring. If you are occupying your beds at 90 to 95 per cent, which looks good statistically, there is something wrong. What happens if an emergency occurs? That means they are stacked up during the week, and probably the weekends are low, because every hospital, I am sure, will have this kind of a pattern.

**Mr. Pope:** Would that problem be met by the 80 and 90 per cent figures on an average, folding in the length of stay? Would that be met by that or are you looking for something in addition to the 20 per cent cushion on obstetrics and 10 on surgical?

**Dr. Vail:** I think we are falling into a trap here of talking about one hospital and applying it to a general situation. Many hospitals have unique circumstances. For instance, I practise from York County Hospital in Newmarket. Weekend accidents are a problem for our hospital. Another hospital in another area of this province wouldn't face that particular problem.

We don't know this coming weekend whether we are going to have a lot or a few. That's what we mean. But that hospital has to be ready and available to give its services to these patients. That's our problem. When you are working at a very efficient pattern by statistics, 100 per cent occupancy over the year, that hospital is in trouble. Does that make it clear?

**Mr. Pope:** Yes, it does. Thank you very much.

Just a couple more questions, Mr. Chairman, I am sorry.

You pose a series of questions under district health councils. Are those your observations, and is that the reason you are posing the questions? Or are you posing them out of a generalized concern?

**Dr. Vail:** Well, both. In the last three or four years the Ontario Medical Association

tion has met with all the doctors involved at one level or another of district health councils. I am talking about whether they sit on the council or otherwise. We have done this on an annual basis to sort of monitor what is happening in the district health councils in the province of Ontario. Over these years we have developed certain attitudes, and these attitudes which we are expressing to you here today.

**Mr. Pope:** Right. So these questions really indicate that you feel perhaps that this is the situation.

**Dr. Vail:** We feel it is correct, sir, or we wouldn't have placed it here.

**Mr. Pope:** Okay. Right. Those are all the questions I have, Mr. Chairman. Thank you.

**Mr. Chairman:** Thank you, Mr. Pope. I should indicate that I really don't feel we can go beyond five o'clock, and I still have Mr. Sweeney, Mr. Ramsay, and Mr. Conway. Mr. Sweeney?

**Mr. Sweeney:** I will defer to Mr. Conway, Mr. Chairman.

**Mr. Chairman:** Okay. Mr. Ramsay.

**Mr. Ramsay:** I have a short question, but it might be a lengthy answer, a philosophical answer, so I am prepared to pass on it in the interests of time.

**Mr. Conway:** Mr. Chairman, just two or three questions. The first is, Dr. Reese, you are associated with St. Joseph's Hospital, I believe, in London?

**Dr. Reese:** That's correct.

**Mr. Conway:** Did I read an article not too long ago where yours was a hospital that was now sending out to prospective candidates for admission a rather straightforward request for any financial assistance that might be provided?

**Dr. Reese:** That is correct.

**Mr. Conway:** Has that ever happened before at St. Joseph's Hospital?

**Dr. Reese:** No.

**Mr. Conway:** Is that something that has happened as a direct result of the new bed cuts?

**Dr. Reese:** It's not so much the bed cuts as the dollar cuts.

**Mr. Conway:** It's the dollar cut I should have said.

**Dr. Reese:** Because the budget identified first that there was an excess of beds, then you lost \$12,000 per excess bed. That corrected your budget, then you got your 4.5, so we ended up with a two per cent increase for the budget for this coming year. So we had several choices. One was to deci-

mate the hospital by closing over 100 beds, and we elected not to do that. The other one was to appeal to the community, and particular to the patients using the hospital. So they got this letter explaining to them the problems with our budget, and that the shortfall was roughly \$12 a day, and that we would appreciate a tax-deductible donation from them. It got us some good news and the wrath of the ministry.

**Mr. Conway:** And what? What was that about the ministry?

**Dr. Reese:** About \$6,000 over a month.

**Mr. Conway:** What was the comment about the ministry?

**Dr. Reese:** The wrath.

**Mr. Conway:** And the wrath. But you have garnered about \$6,000.

**Dr. Reese:** This is correct.

**Mr. Conway:** So in a sense, is that something that any other hospital in your area has ever had to do before?

**Dr. Reese:** To my knowledge, no hospital in Ontario has ever gone out begging.

**Mr. Conway:** It was barefaced begging as far as the hospital was concerned?

**Dr. Reese:** That's correct.

**Mr. Conway:** And \$6,000 worth of tax-deductible but none the less user charges of a sort were collected.

**Dr. Reese:** "User charge" implies that you are charging it. This is a voluntary contribution. It's a silver collection after their admission.

**Mr. Conway:** But it was directed at the prospective users, as I recall.

**Dr. Reese:** That's correct.

**Mr. Conway:** That's correct. I just think it's important for members of the committee to know that that perhaps isolated but none the less real case has occurred as the result of this hospital restraint.

[5:00]

Two points: My colleague the member for Oshawa (Mr. Breaugh) — and I thought it would be interesting to hear that he was as congratulatory as he was today with respect to the Ontario Medical Association for a brief about which I share his point of view in the positive—talked earlier about, and I believe I paraphrase his comments accurately, regretting the failure of perhaps hospital administrators to generate the kind of commentary that you have done, alleging perhaps the work of an old-boy network.

I wanted to ask you to comment on the old-boy network, since many would argue you are in a preferred—



**Mr. Breaugh:** That's a polite phrase. I want you to know that's parliamentary language; there's a more realistic description of that.

**Mr. Conway:** Since many would argue, Dr. Vail, that yours is an association which is in a preferred position to comment on the old-boy network, do you see a problem in the way in which the dialogue occurs between the hospital association and the ministry, and the ways in which appeal mechanisms such as you have described could be rendered more useful? I, like Mr. Breaugh, was quite unhappy about the fact that we heard an awful lot of complaining but found, not surprisingly, that we could not get very much identifiable evidence because people who are in charge of those hospitals were naturally reluctant to come forward to a group of politicians who did not represent the same mandate as the government to which they would tomorrow go for money.

**Dr. Vail:** I have a couple of comments, Mr. Chairman. One is that I noticed the press release or statement of Mr. Breaugh in this regard. Secondly, I am not too sure that we are in any old-boy network.

**Mr. Conway:** It would just give you the chance to say no.

**Dr. Vail:** Thirdly, and probably most importantly, I have, in my own mind, tried to analyse why they don't come forward. I think there's a thing called pride here. I think you noticed testimony here today from Dr. Reese. When you face a hospital representative or a doctor in a public forum, one of the things they are reluctant to do is say, "Man, we've got troubles. We've got troubles that are jeopardizing the health of our community." That's a very tough statement for them to make. Their pride, I think, prevents them from making those kinds of statements. I would hope that it's not that they were going to upset somebody who will come back at them.

I don't think that's the meaning you are trying to put on it. I don't think that's fair. I think it's this pride element. I know chairmen of hospital boards are reluctant to hear some of their doctors come to an open forum, such as you have, Mr. Chairman. They say, well, this may reflect badly on our hospital. So it's a difficult situation and one that I recognize and obviously you have too.

**Mr. Conway:** My final question, Mr. Chairman, deals with an impression that I have and I wanted to get your association's comments on it. It deals more specifically with the appeal mechanism.

I guess because I have the impression of a minister and a ministry which has undertaken a major restraint program, guided not so much in my view by a careful health-care planning policy but rather by the immediate exigencies of serious financial restraint, and a minister who I think is zealous and concerned but, on the other hand, with very little effective control over the planning mechanism such as exists within his ministry, I am attracted to what Professor Fraser Mustard has mooted as a proposed, not so much appeal mechanism, but just a mechanism for the publication of comments such as I think you are directing our attention to here.

Professor Mustard has suggested some sort of buffer agency, an elite body of health-care professionals and community types, a small number that could, on the basis of its own expertise and evidence and experience, sit in judgement of health-care planning in the province, and once a year meet the Legislature and release a public statement about the way in which health-care policy is being presented and pursued in the positive and the negative, to alleviate the old-boy problems that might exist between the hospital association and the ministry, to alleviate the burdens of the housekeeping relationships that may exist between the medical association and the ministry.

What do you think of that kind of proposal, whereby such a body would be struck to meet publicly at least once a year to declare a statement of opinion which sometimes, hopefully, would be positive but presumably at other times might be negative in its expression of opinion with respect to health-care planning in the province?

**Dr. Vail:** It's always difficult to answer a problem which you haven't had an opportunity to study and approve, but the basic thesis of this is to open up this whole subject matter. If that's what the basic thesis is, our association would be very much in favour of it. I think the thesis of our presentation today is really that we're saying this system is underfunded.

I really believe, Mr. Chairman, that your committee shouldn't be looking for gimmicks and they shouldn't be looking for scapegoats, whether they be the Minister of Health or the medical hospitals or the doctors. But really you have a very simple problem. You've got to get more money into that system. I think that responsibility is yours as parliamentarians, and that is the basic problem, as we see it, with the whole health-care system in this province. How that's to be obtained is your responsibility.



**Mr. Conway:** We won't engage you, then, finally, to comment perhaps on the nature of that infusion, knowing as we do that your association holds dear to the argument that the time has come perhaps to infuse non-public funds.

**Dr. Vail:** Mr. Chairman, you have other alternatives. They may be politically tough decisions to make, but you have the alternatives of increasing taxes or removing funds to other departments of government and moving them over to health. Those are tough political decisions, and I recognize them. But I think they're decisions that you and your committee will have to face up to.

**Mr. Kennedy:** If I could, doctor, in the opening preamble, one and two, you indeed pay tribute to the quality of health care and then bring forward some points of criticism, if you like, or deficiencies and so on. I'm just wondering whether you see merit in the efforts; whether there can be some inter-administrative, I suppose I could describe them as that, changes to try to accommodate the needs and meet the health-care needs of the province and yet have some element of restraint. I heard the minister speak at our annual meeting at Mississauga.

**Mr. Chairman:** Your supplementary, Mr. Kennedy.

**Mr. Kennedy:** He mentioned the request for capital funding alone: \$800 million. We have something in the order of \$88 million to \$100 million this year. If you said we have a third of the population, and this was extended across the province, presumably across the whole country, that would total \$2.4 billion for capital plus the servicing and the attendant costs that would go with operations. Do you see any middle ground or merit by which we can achieve—for instance, as a quick example, the effort of switching active-treatment beds, which are very expensive, to chronic, and things internally such as this.

**Dr. Clarke:** Once again, that's probably a shopping list he's talking about. Every hospital came in with a big shopping list for capital equipment. If there was a consultative process where the outside providers and the ministry could plan together what's on that list that's feasible for the province and what we can afford, okay. "You guys, you know, you're out of your mind asking for all that. Here's all you need." The OMA and, I'm sure, the OHA would stand up with the minister and take the castigation from local communities that, "No, you're out of line," or, "You're not too far

out of line but the other community has more priority than you have." But we don't get that. We get isolation. We are informed after the event and it's implied that we need it anyway.

**Mr. Kennedy:** You mentioned underfunding in your closing remarks, Dr. Vail. How much would you be talking about?

**Dr. Vail:** I have no idea, sir. The minister made a statement which I would presume is correct and has a certain validity. I wouldn't want to debate it, but I think you hit the key and he's hit the key. It's underfunding. As I pleaded with your chairman, don't look for gimmicks or don't look for something. You've got to get more money into that system. Where you get it from is your political choice. I think that's the thesis of our arguments today, sir.

**Mr. Kennedy:** There's got to be some space within the present system for economics.

**Dr. Vail:** Oh, always. It's \$4 billion a year. I would recognize that. But don't try to save a billion out of the \$4 billion, sir.

**Mr. Kennedy:** It's never been reduced, doctor, as you know. It's the amount of increase and the rate of increase that's of concern.

**Dr. Clarke:** Maybe in absolute dollars it's going up. But remember the 1971 dollar. It's \$1.88 in 1979, and that's from the editor of the Financial Post, who's my neighbour. So talk ratios, not absolute dollars.

**Mr. Breagh:** We have the best kinds of witnesses. The editor doesn't live next to me.

**Mr. Chairman:** Dr. Vail and Dr. Reese and Dr. Clarke, we certainly appreciate your attendance here. Your organization is a key organization whose members are certainly central to the delivery of good health care to the people of the province and, indeed, Dr. Vail you have acted as a very important resource to this committee this afternoon. We thank you very much.

**Dr. Vail:** Thank you, sir. I can only add that if you feel or your members feel that other experts within the health-care delivery system and the physicians are wanted, we'll use our best offices to obtain them for your committee of it's your desire. Thank you, sir.

**Mr. Chairman:** We appreciate that. Thank you. Now we have the Wellesley Hospital. Dr. Charles Godfrey, Dr. Hugh Smythe, Dr. Bean, Dr. Shire and Mr. Thornton. We have Mr. Bennett and Mr. Krasny as well this afternoon.

**Dr. Smythe:** I'm Hugh Smythe. I'm a professor of medicine at the University of

Toronto, vice-president of the medical staff of the Wellesley Hospital, and also involved with the Arthritis Society, so I'm here from three points of view, not as a formal nominee either of the University of Toronto or the department of medicine or the Arthritis Society, but speaking from my knowledge of these.

We have been quite concerned in the medical staff and within the university community at something which was alluded to by several speakers, and that is the nonresponse by our representatives. Our professors and our deans and our chairmen of hospital boards and others have not made what we feel are effective response to a threat which is growing to our Toronto hospital community, to the university hospital community in particular and to the Wellesley Hospital as an example of that community. They have not made any effective response at all. So here we are.

We've been doing a little bit of homework on the kinds of questions you've been asking, the kind of data you've been asking to hear. I'm sorry, I just heard about this this morning and our Xerox machine broke down. I have seven copies which I could distribute to members of the committee as background material to illustrate the kind of data I'm prepared to offer in the first place.

I want to speak first of all to the situation about hospital beds in Metropolitan Toronto. As you know, until recently the standard was four beds per thousand and has been recently reduced to 3.5 and it's been said that the number of beds currently in Metro Toronto is 3.9 per thousand. These figures are not correct. They are based on an inadequate allowance for the referral population and inadequate consideration of other factors. In the material I'm passing around, I'm giving you some of that information.

There were, in October 1978, just over 10,000 beds in Metropolitan Toronto and of those 10,000 beds, 2,321 were occupied by nonresidents of Metropolitan Toronto. I've attached as the last two papers in the documents the bed occupancy by Metro residents and Metro nonresidents. That left only 7,850 beds to serve the Metropolitan residents, which gave them, as of October 1978 when the norm was four per thousand, just a little over 3.6 beds per thousand.

Even those figures do not show the complete story because, as we are talking, the focus is not on bed cuts. The focus is on financial cuts. To live within the financial constraints that were presented last year, our hospital closed 185 beds during the summer months. The average bed total through the 12 months by these closures was 60 beds lower than we are rated.

[5:15]

We know that those similar closures occurred, particularly in the teaching hospitals in Toronto, and so the slight excess over 3.5 actually disappears. When we were supposed to be at four beds per thousand, we were already at 3.5 beds per thousand. A short time ago the ministry projected a cut of another 1,000 beds in the Metropolitan Toronto hospital system, again to be borne largely by the teaching hospitals. If they go through with that and we carry these figures through to 1982, which is our target date for the bed closures, at that stage we would have, instead of a mild surplus on the 3.5 target of 341, a mild deficit—a deficit which would be about 400 without bed closures, and about 1,400 with the 1,000-bed bed closures. So we are not just in the tight situation which has been described, we are in a situation which frightens us quite markedly.

It's hard to know what is the right figure. The medical profession has been increasing its productivity through the decades, probably more efficiently than any group other than the farmers. I know in my own field of arthritis, the average length of stay for an arthritic patient back in the 1940s was six months. In the mid-1960s, it was down to 37 days. Now it's down to about 17 days and we're looking after them with better results and at cheaper costs. I mention this only because it's something about which I have the figures at my fingertips, but you could parallel this with the operation of almost any other department in a good, well-run hospital.

However, we are talking hospital beds, so in the second page of what I've handed out to you, I've got bed statistics, the number of active beds around the world. In a select committee you had here a year ago, they rather proudly announced we had fewer beds in Ontario than in any other province except Newfoundland, and I don't know where we stand with regard to Newfoundland at this moment. But you can see we have fewer active beds per thousand than any other country in the civilized world. Portugal's the only one that comes close, at 3.8 as opposed to our 3.6.

In the teaching hospitals, as I mentioned, the situation is in some ways similar to that of the other hospitals. I'm glad about that. I don't want to put a special case for the Wellesley Hospital as opposed to Scarborough. I think this tight funding is hitting all Metropolitan Toronto hospitals. I do point out on page three, the 1,457 patients in Toronto teaching hospital beds are a very special kind of patient. These are the tertiary-care problems. They are the ones who have chosen to



leave their own home community, and come to a special centre because their doctors have identified problems of special difficulty, requiring special facilities and expertise for their care. We're proud to be part of that system. We're proud that we have a system in Toronto which is, I think, one of the major tertiary care referral centres in the world. We have with it very heavy teaching responsibilities, and research responsibilities. We within the university community feel very deeply threatened that if, say, that 1,000 bed cut falls within the Toronto teaching hospitals, particularly on the teaching hospitals, that our ability to function at this level as a tertiary care centre, will be put in serious jeopardy.

We have said we're dealing with bed ratios only as an index. It's a changing index as our productivity increases the ideal number. We have been collecting data on what happens to our hospital system as a system, not just as a number of beds, during the summer closures that I mentioned last summer.

I speak again of the arthritis service, because it's the one I have most knowledge about. Ordinarily, people are referred to us because of some condition which is either very painful, or a systemic illness, which is very frightening. Ordinarily, we are able to give the referring doctor an appointment within about two weeks to get a complete, thorough referral. This is an outpatient consultation, to see what kind of facilities or depth of investigation seems to be indicated. We run a teaching service, so that the first person who sees that patient will be a senior trainee in rheumatology. Of course, that must be backed by the consultants who will then see the patient right away, and assume the proper responsibility for making sure that care is given.

During last summer, the waiting list, which is normally two weeks, grew to six weeks, eight weeks, 10 weeks and finally 12 weeks. The reason for this was not an increased number of referrals during the summer, although to some extent that occurred, as people became panicky. The reason was that more and more things came up that could not be dealt with by any other means than the patient being seen on an emergency basis, at all sorts of places around the hospital in an unsupervised way.

We felt very anxious that we were not giving the quality of service that we would otherwise give. Certainly, a 12-week delay for many patients is intolerable and unsafe. We believe that some patients' illnesses were not treated as well as they should have been

because of these circumstances. We are collecting details on this. Obviously it's an extremely sensitive matter, having to do with patient confidence and doctors' liabilities, hospital liabilities. So that statistics on this kind of thing are not likely to be readily forthcoming, but there are certainly things that happened.

Through several of the discussions that took place after the earlier discussion, a lot of questions were asked about the involvement with the ministry, or through OMA, or through the regular channels, and why people do not come forward. I started off with a complaint on that level. My colleague earlier said it was pride. I think it may also be fear, but certainly it is happening that people representing our hospitals and our university are not feeling content to come forward.

I've been trying, personally, to talk with the ministry over these matters. I don't want to call it the runaround but certainly my colleagues and I have had no warm invitation to come and join with them. I'm delighted this committee is sitting so we have a chance at least to get our arguments on one table. I don't know what would happen if it were not sitting at this particular moment.

There are all sorts of things that we could talk about. The planning; much of the stuff that goes on in your planning seems nonsensical to us—the chronic patient who has been in the hospital for two weeks; pardon me, well, over four weeks. That's when we begin to look at them as chronic patients. They require only three meals a day, the odd change of linen, and minimal nursing care. Their expenses are not really higher in the Wellesley Hospital than in the Riverdale.

We are doing studies of costs and benefits of various alternative systems of delivering health care. We have figures to back this up; exactly what is delivered to that patient. So it makes sense to get them out of the acute hospital and into the chronic one if your beds are being jammed up by patients who don't need the facilities. I think that argument is fine, but it won't save you a nickel. It's not central to the method of saving funds, if there are inadequate numbers of active-treatment beds.

Mr. Chairman, as I said, there could be large numbers of things I should talk about. I wanted to bring forward these matters on the bed numbers, which we think have been under the severity of the cuts. I think we have been underestimated and the data not provided for you. Certainly, it has been



hard for us to get any more up-to-date data than I have. I've wanted to make a special explanation of the nature and importance of the tertiary-care system. Some of that was earlier mentioned. To our mind, there is a very definite gap in the planning mechanism as these very rapidly introduced funding strictures have fallen upon our community.

**Mr. Chairman:** Thank you very much, Dr. Smythe. I should mention to the committee that we still have two briefs to go, and I really don't see how we can do much beyond 5:30 p.m. I do have Mr. Johnston, Mr. Ramsay, Mr. O'Neil and Mr. Sweeney.

**Mr. R. F. Johnston:** In view of the nature of the submissions we're getting now, I think it's important that we do spend time with them.

**Mr. Chairman:** I should say on that point that I'm quite prepared to sit somewhat beyond six o'clock in order to complete, but at the same time I just want to underline that we are short of time.

**Mr. R. F. Johnston:** Well, I'll just forge ahead.

**Mr. O'Neil:** Could I just interrupt to ask whether either of the other two doctors has any comments to make?

**Dr. Bean:** I'm Dr. Irwin Bean, the chairman of the medical advisory committee of the Wellesley. I apologize for not having a written brief, but we put it together on the basis that this was an open forum and that it was with, as Dr. Vail referred to, a certain amount of pride that we decided to take hat in hand and bring it forward.

As Dr. Smythe mentioned, there were a number of instances last year when we closed. With 186 beds for 81 days, we had the opportunity of looking at it and seeing what the impact of this was on the community that we served. I think the Wellesley is a very special community with very special problems. By its nature it is a teaching hospital, it's a tertiary hospital and it is the second highest in terms of referral from outside Metro Toronto, the first being the Toronto General. About 25 per cent of our patients come from outside the city at any one point in time.

We also function to a certain extent as a community hospital, which has the highest concentration of population of any place in Canada on its front doorstep, namely St. James Town, and that is expanding. In St. James Town there is a disproportionate number of aged, and also people with disabilities, so this puts us in the midst of a high risk population. To the south is that

area of Toronto which has the highest mortality rate from alcoholism of any place in Canada. So we are in the centre of a place of excesses.

Because of budgetary constraints, and I would like to point out that our budget is up this year over last year, and it was up the year before over the preceding year. Unfortunately, the rate of increase has not been sufficient to keep up with the inflationary trends and the cost of the devaluated dollar on the goods and services that we have to purchase from the United States. It's just as simple as that. How much do your groceries cost this year compared to last year? Believe me, we buy groceries too, in the hospital.

So it's been this failure to keep up to date or to keep up with the inflationary trends that has really put the budgetary squeeze on the hospitals. As we attempted to analyse it, we looked at cases and we said could we document cases where medical care was adversely affected? This is awfully difficult, and indeed, as Dr. Smythe has indicated, it is a very sensitive area. We really couldn't pin anybody down and say this patient died because he didn't get into hospital. This was the kind of thing we were looking for.

What was the impact? We noticed, for example, that the volume of laboratory work, in spite of closed beds, has remained a constant because the demand for outpatient services as reflected through the emergency and the outpatient departments has remained a constant. The turnover time in the labs increased.

We looked at patient inconvenience, and again, how do you quantitate this one? Mr. Jones is booked to come in for surgery. He's planned his holidays at that time. He can't get a bed, and he loses income as a result of it.

We consider the number of patients who were brought to our emergency who had been previous patients at the Wellesley, which had their records. We didn't have a bed for them. They had to be transferred to another hospital at their inconvenience, with the ambulance service waiting, and again with additional cost to the system because of the lack of availability of the records which were on site. Therefore, this caused more duplication of additional investigation which we had, and which we couldn't transfer immediately at that point of time, but which would have been there.

[5:30]

Again, as Dr. Vail indicated, the effect on staff morale—and I would point out that a

hospital staff, not just medical and nursing but indeed the entire labour force within a hospital, is a very special one. It's all very well to have a cleaning woman who comes in and cleans our household, but when you're dealing with infectious cases and the risks that go with them, our cleaning staff have to be very special. Again, how does this affect their morale? We couldn't quantify that, but we did get the kind of feedback to which you referred, where the OR staff was just being stretched too far. Operations were going on until 3 a.m. The laboratory staff were stretched.

Did it adversely affect medical care? I can't state. With reduced budgets, indeed one looks down the line and says: "Well, what kind of a house will we be living in five years from now if we can't do the maintenance on it?" This is another facet we looked at.

We also have an educational function. I had a number of students who came to me and said, "Dr. Bean, I was on such-and-such a service when the beds were closed, and I want to repeat it again next year because I didn't get the experience I needed."

Again, these are anecdotal, but as Dr. Vail says when you start to hear them and they start to pile up, indeed one does begin to listen. I think we have made an honest attempt to provide, as has been suggested, alternate methods of health-care delivery. Again, you reach the bottom line when you can't go very much further.

About six or seven years ago we opened up a health centre in St. James Town to provide on site a community health service for the people who lived in those apartments. In the one I have 31 people who are confined to wheelchairs or crutches and 13 blind, and all ranges of disability in between. Yet in spite of the fact that this is a high-risk area, by virtue of providing the care there we have been able to cut their expected hospital admission rate down to about one half of what one would expect from a normal population, let alone from the high-risk group with which we were faced. Believe me, the consultant rate was up, the consultant rate was over double; which again one would expect, but this is the providing of a care.

How much fat is there in the system? We went through the Woods Gordon study which was brought on by the OHA and we've cut the administrative budget to the ultimate, but we're still faced with the problem, this year, of having to close 186 beds for a period of 81 days, and they are closed at the present time. I think that to react to what Dr. Vail has said, somehow or other society collectively

has to look at how much it can afford to pay and there has to be some money put into the system to meet it. I think that's really all I wanted to say, Mr. Chairman. I have with me Dr. John Provan, who has been chairman of the task force that we've had looking at budgetary restraints. If Dr. Provan would like to add something I would be pleased to have him do it.

**Dr. Provan:** I'm an associate professor of surgery at the University of Toronto and at the Wellesley Hospital, and I'm head of the division of vascular surgery. I'd like to talk about some of the other responsibilities that I have in the hospital, where I'm chairman of the operating room committee. That's the committee that runs the operating room and is concerned with its management and day-to-day operation; as well as with the intensive care unit of which I'm also chairman of the management committee at present.

I've also been concerned for some while about the bind I see us being put in as doctors, to which all the witnesses of this committee today have referred, and that is the impossibility of trying to define quantitatively what is actually happening in terms of the effects of these bed closures. I think the ministry gives us figures and expects us to refute those figures by other figures, which quite often are figures we can't get until after the event. Although, as you heard, we did lose 185 beds for the summer period last year, the quantitative effect of that is really not very apparent. How many patients have to die before those bed closures become important? How many medical students have not to be taught? We can't quantify those, and that's my concern.

I am going to talk about some of the qualitative things that have happened, particularly with regard to the operating room. If I may just take you back for a moment or two: we are a teaching hospital, as Dr. Smythe said, and we have responsibilities other than those of just pure patient care. These come into various categories, including administration, research and teaching. In order to do that, we require bodies. One of the things the heads of the various departments of surgery and medicine do is try and pick out people who are presumably going to be eminent in their field—that is if you can do that ahead of time—and they may offer them a position in the hospital because they are going to contribute in one of these four areas.

This tends to happen down the line. In other words, you may see somebody who is going through his residency training and you may say: "Okay, he's a suitable chap; we'll



get him back." He may then go away for a further period of training for a year or two. This has happened in the department of surgery, and in various other divisions. These students are invited to join the staff, and of course in addition to their requirements for research and investigation and that sort of thing they also require operating room space.

Last year things came to a crunch in the operating room at the hospital. It runs seven operating rooms, which function at a capacity of about 80 to 85 per cent utilization of the elective time that is available during the day. You may think why not 100 per cent? I can tell you that the American Hospital Association and various nursing and operating room associations in the United States recommend 60 per cent as being the absolute maximum of utilization of elective time in operating rooms, because of the pressure of work and the anxieties that occur when work is rushed.

We've been working at about 85 per cent. We have seven rooms that do this, and we had four surgeons who were fighting for time to work. Because of their reputation and expertise they get referred patients and they require time to operate. We went through this and decided that if we could find three nurses we would be able to open an eighth room. We have 10 rooms, actually, but we use only seven at a time.

Of course there was no money. We are not turning the clock back on those people who have been approached years before—two or three years before maybe—and who now are coming to expect the same sort of privileges and priorities that everybody else has in the department of surgery but are finding we can't give them operating time.

What we eventually did was to cut the operating time for various individuals. This caused almost a revolution. I used to walk around that hospital with my back to the wall because I was afraid that somebody was going to stick a knife in it. They were getting it in the neck from their patients. We looked up the orthopaedic waiting list, it was going up to three months for some patients.

Now I don't know that anybody suffered as a result of this, but it made it extremely inconvenient for patients. It made it very difficult for the resident staff and for the nursing staff. The incidence of illness went up; nurses were taking more time off work; arguments went on between the nurses who were being hard pressed. I don't know that there was any specific instance of a problem that arose as a result of it—and though I think that, I wish to bring it to the attention

of this committee if there were it would have been for the reasons that people have stated already—but there certainly was a very much worse atmosphere in which staff worked. We have a notice board in the operating room where the names of patients requiring emergency admissions, emergency operations, are placed. Space on this board was crowded every day; not with the names of patients who had to be operated on immediately, there was never any problem about that, but patients whose operations were required to be done before the next elective operating time. The order was that unless there was any specific urgency about it, if it was assumed the patient couldn't wait until the following day, they were operated on in turn as their names were placed on the board.

Now that sounds easy, but in fact people were getting delayed; operations were being done, as Dr. Bean referred, at 3 a.m. Resident staff was tired, surgeons were tired. It surprises me, and I think it's a credit to the medical staff involved, that more accidents didn't happen.

Finally, after a great deal of effort on the part of the administrative staff of the hospital, we obtained the salaries for three nurses. We didn't ask where they came from, but they were obtained. We were able to open an eighth room. It's like night and day. The board is empty. We have flexibility in the operating room, which we didn't have before. Patients who come in with abdominal pain and who may have appendicitis but who don't require urgent operation are done quickly instead of having to wait. The surgeon isn't being forced to make decisions because of expediency. It has made an enormous difference to staff morale, which Dr. Bean has already referred to.

Now you can't quantitate these things. It's very hard to do this. The efforts by our administration in speaking to the ministry have really just met with the inflexible attitude, I think, that our hospital is only rated at so many beds and that's what we are getting.

The reduction of bed numbers has undoubtedly made a difference to waiting lists. We see them going up. It's of considerable concern to people who are dealing with situations that may be life or death, people with coronary-artery disease, who have to wait a longer time for admission to hospital because they can't be got in. These, again, don't happen to everybody, but it does make this sort of brinkmanship occur.

As far as the intensive care unit is concerned, we were given private money some



years ago, as a result of a patient who in fact had served on the unit that Dr. Smythe now runs, to build the best intensive care unit, really, in the country. At that time we think we did, but we were only able to open 16 of the 27 beds we planned for.

This planning, I may say, was done in full association with the Ministry of Health, with whom we had close relations on the project, but at the time the unit was due to be opened, officials of the ministry said, "No way, you can only open 16 beds".

That in itself puts pressure on the hospital. The hospital gets known as having good facilities. People want to send patients there. We are faced, as I was the other day, with having to send a patient out of the intensive care unit, although I was a little uncertain as to whether she was fit to be nursed on the ward, because somebody else had to go in there. As it happened, that patient had to come back and was worse off as a result of this.

Anecdotal accounts such as that really serve to make the point. They don't, unfortunately, serve to convince the ministry. But I can tell you that the closure of 185 beds for the summer, which is what we're doing now, and which is going to reduce our overall bed complement from 604, which it was in 1971, to 519 for this year, is making a pronounced impact qualitatively; not only on patient care but upon the students whom we teach. I have a major role in teaching in the university where I run the fourth-year surgery program for the students, and there have been many complaints about the lack of clinical material. Patients soar during the summer months; patients who had to be referred to other hospitals, or had the good fortune to have beds at that time.

Dr. Bean has already referred to inconveniences to patients. The patient who waits two months to come in finds that he can't get in because the beds have been closed; he waits another two or three months, and by four months it is intolerable. It's approaching the situation, I think, which existed in Great Britain before I left it to come here in 1969. I'm glad that your committee is able to look into this problem, because I think you have a very serious problem on your hands.

**Mr. Chairman:** Thank you, doctor. Mr. Johnston.

**Mr. R. F. Johnston:** Doctors, thank you very much for coming; this is really a double whammy presentation we're getting this afternoon. I'm Metro Toronto critic for our party, and it's very disturbing to hear

figures such as you raised with us, Dr. Smythe. We were not aware of them in the past; I'm quite concerned about what effect this has on Metro.

Can you tell me why it is that you are the first person to come before us and tell us there are nonresident beds allocated in Toronto? I mean, this is the first I've heard of it. I don't know about any other members of the committee, but—

**Dr. Smythe:** It is the first time I had heard of it as well. It became evident when I worked out the figures. I couldn't do it until I could get these last two pages, which were the figures on separations from outside Metropolitan Toronto as well as total. That's only for one month.

My first response on doing the mathematics on this was to send the figures to Mr. Timbrell and ask him to correct, verify, update, see if there were errors in the mathematics. That was on April 4 after a big meeting we had. I still have not had any updating, correction, verification, on these. So that the raw materials have not been available to us and they have not been available to you.

**Mr. Breaugh:** Are you saying, doctor, that the ministry sat on those figures from April 4 until now?

**Dr. Smythe:** They made them available to us. I've requested their response, and they have not yet come to me.

**Mr. Pope:** I'd like a clarification. Where did you get the figures from?

**Dr. Smythe:** The basic figures, which represent the summary, by place of residence, of separations, were in a ministry document that was provided to the hospital. The other calculations are my own.

[5:45]

**Mr. R. F. Johnston:** But according to your figures, of the 10,000 beds in Metro 2,321 were used for nonresidents at that stage.

**Dr. Smythe:** That's right.

**Mr. R. F. Johnston:** Which leaves 7,850, which is the 3.6 per thousand at that stage.

**Dr. Smythe:** At the present time, yes. Only that does not factor in the summer closures, or the fact that some of the beds may be misused as chronic beds and therefore are not available for active treatment.

**Mr. R. F. Johnston:** How many beds do you think that would take?

**Dr. Smythe:** I think it's rather small. I think they've been aggressive and efficient, and we have a fairly good home-care system, so I would think it's less than 10 per cent, but it may be of that order.

**Dr. Provan:** Excuse me, but I inquired about that in response to a conversation I had with Mr. Timbrell in early April. Fifteen per cent of the beds in our hospital were patients waiting discharge or placement.

**Mr. R. F. Johnston:** Okay, 15 per cent. How common is it for Metro hospitals to close during the summer? Are you the only ones who have done this?

**Dr. Smythe:** Some summer closures were reasonable, as the Metropolitan Toronto residents and Metropolitan Toronto doctors and staff took summer holidays. So 20-bed closures and so on were not uncommon. The large-scale closures which you see now have only occurred for the first time last summer, I think, and are coming into the second summer of it now. I do not even have a summary of what all the closures were during last summer. Dr. Bean do you have that summary?

**Dr. Bean:** I had a summary at one time which I dug out of UTHA, which is the University of Toronto Hospital Association. It ran in different patterns and it was almost like pulling teeth to get it, I must confess, even from hospital to hospital. But certainly all of them did close some beds. Some of them did it on an annual basis, and some just blocked out, let's say, 100 beds and that was it. There are some that got by with 45 or 50, but the problem was to stay within the budget. I'm sorry I can't give you the hard data on that.

**Mr. R. F. Johnston:** It's just interesting to know that what started primarily last year in a large way was always done in one sense or another in a small fashion. We continually hear the Ministry of Health has an expectation of X number of beds in a hospital; the actual number that are operating is lower than that. How many hospitals in Metro, from your knowledge, operate the same number of beds that the Ministry of Health budget says they have?

**Dr. Smythe:** Probably none. We wish we had the hard data to give to you, but I think it's probably none.

**Dr. Bean:** That's difficult because certain beds are split off from the categorization, such as for example if you have chronic beds that are calculated, they are listed as chronic beds. We have no chronic beds listed. We do have psychiatric beds, which are a different quota altogether because that comes in under a different grant.

**Mr. R. F. Johnston:** We've had difficulty, as has been alluded to, getting hospitals to come before us and talk this way. Two words have been used now as explanations of that: one is pride and one is fear. I really do hope

that it's recognized that the kind of particular examples that you are giving us today are exactly the kind of thing that we need as a committee. They are exactly the kind of thing which we need to be able to take to the Minister of Health and to use as ammunition to get any changes in this.

I would just hope, since the OMA people are still here and if the OHA people are listening anywhere, that they should be assisting hospitals to come forward and to make this kind of presentation to us, and not feel that in some way or another it's going to jeopardize their good name as a hospital or that there will be any sort of fallback on them. I think this kind of information is very important to us.

The other hospital that came to us was a suburban hospital that I'd like to refer to, and that was Etobicoke, which you have listed as one of your hospitals here. They're also in very dire straits as far as their percentage of beds in use goes. They have an impression that it's you people who are the villains because of the new formula which puts all the Metro hospitals together and that there are all sorts of vacancies in the beds in the inner city that do not exist in the suburbs, and that they, as expanding population areas, are getting hit by it. It's very helpful for us to see today that, in point of fact, that is not the case. Can you tell me any other effects that have come from this new rationalization, this Metro-wide rationalization in terms of affecting teachers at teaching hospitals?

**Dr. Bean:** I left out one thing, Mr. Chairman, and that had to do with research. We had one funded research program that had to be cancelled last summer because of the unavailability of patients at that time.

**Dr. Smythe:** There is a virtual freeze on the hiring of new teachers and there is much less money coming in, not only to the hospital scheme but also through the university budget. So the teachers are being underfunded for their academic activities and we are being urged to find ways of taking money from the funds used to generate patient care, designed to generate patient care, and siphon those funds, if you like, and put them into pay for secretary expenses, or technician expenses, or whatever other things are necessary to keep the academic program going. We feel very anxious and threatened by that, and that's one of our disagreements with our own university structure.

**Dr. Provan:** I'd like to comment on this as well, in that the number of residency positions, the people who have graduated and



are now in training, has been reduced considerably in this province, in all the schools in this province. This is undoubtedly going to affect people who have already offered positions to train, for example, in surgery, because there is no money available. That money has been reduced. This ultimately is going to affect the involvement that all of us as teachers and investigators and as administrators have, because presumably our first responsibility is going to be toward patient care. We work as a team. The fewer members there are on the team, the less time there is available. This is already beginning to have an effect on some services which are beginning to be left without residents.

**Mr. R. F. Johnston:** Just to back a little bit in terms of the overall number of beds that are available. We continually hear, and it comes out again and again, that the beds in the inner-city hospitals, up to a thousand of them, are not in use—are excess, if you will. That's why people from the suburbs can go to those hospitals in the inner city if the suburban hospitals are crowded. From what you're telling us, that is not the case. There are not 1,000 beds. How did we get that figure? Could any of you respond to that?

**Dr. Provan:** The document I have here interested me as I was reading it the other night. It describes the bed allocation method, refers to the statement of number of inpatient beds within broad care designations that the Ministry of Health plans to provide given the available fiscal resources. I wonder which comes first. It's a chicken and egg situation. I suspect the fiscal resources come first and then the number of beds conveniently fits that. This is a concern. I think maybe some of the older hospitals have fat to spare in terms of large size. But certainly we don't get people who specifically come to the teaching hospitals because they have beds. The patients don't want to do that. It's less convenient than going to a downtown hospital when you can be managed. The patients who come out of the immediate area are people who have been referred because we are tertiary-care hospitals.

**Mr. R. F. Johnston:** Right. Does the same thing happen as they were talking about? That is, they have doctors who are affiliated with their hospital and the patient is likely to stick with the doctor in his hospital rather than go downtown. Does that same thing happen with your hospital? Are people who are affiliated with doctors at Wellesley not likely then to be shifted to another downtown hospital, where that doctor perhaps doesn't have rights?

**Dr. Smythe:** I can't speak for the whole system, but our own is to strongly urge the patients to have their own local doctor based in their own community. This is pretty general practice. They only come to us on referral from their own family doctor, having exhausted the local resources. I think this is the only way the system can properly work.

**Mr. R. F. Johnston:** I have a question that goes back to the OMA's presentation, which is to do with taking into account other factors than just the straight bed-count formula. You mentioned the existence of St. James Town and the other areas south of you there. A high-risk area is what you called it, Dr. Bean, and I'd agree with that totally. Have you or your hospital asked the ministry to take into account the special nature of your area when negotiating?

**Dr. Bean:** Yes, indeed. I would point out that it was with ministry support that the St. James Town health centre was opened to attempt to provide ambulatory care services for the group of people in this area. On this one there has been good support from the ministry. I happen to be the chairman and the professor of family and community medicine, which is a little different ball park than my consultant colleagues on whom I'm very dependent and with whom I work very closely. That was the point I was making when I said 25 per cent of our populace comes from outside of Toronto but we also have a community function we serve, which includes the other practising physicians in that community. I operate a teaching unit, but the others who are practising full time in that community do use the Wellesley as a referral centre.

**Mr. R. F. Johnston:** I wouldn't want to downgrade that involvement and community aspect of it; I guess what I'm trying to say is that you have a hospital which is feeling the effects of cutbacks in general and you're also in a high-risk area as far as you're concerned, and that may be accounted for in terms of that one program that you're operating, but there is the acute care you're providing within the hospital as well and it seems to me you've got a special case that should be taken into account but isn't under the present system.

**Dr. Bean:** In all fairness, I would point out too that we have a close liaison with Grace Hospital which has just been opened recently as a chronic hospital in our vicinity. A number of our staff have cross-appointments so as to utilize the chronic-care facilities that are available in Grace to try to meet our needs. I think that we are, in all



honesty, attempting to meet the guidelines that have been laid down. I have reservations concerning some of them. While I'm in family and community medicine I am all for prevention, and I think our track record on the prevention of many diseases hasn't been too bad, but I think Frank Miller sent it up remarkably when he referred to the problem areas today as the diseases of choice. This involves change of lifestyle and behaviour; and believe me, how you can do this I don't know.

While I would support the minister in his statement, which I think he made to this committee, I think it was the third thing which he put forth as being ministerial policy, that is an emphasis on prevention. I would submit he's going to have to go right back into the public schools to get the concept of an individual's responsibility for his health; into family education and the whole bit. It will take another generation before we reap the benefits of this.

With polio we knocked it out in a very short period of time because you can immunize that, we can do something about it; but believe me, when you come down to public education—for example I think the seatbelt legislation was excellent, and again part of it was a public education program. The impact of that certainly dropped this year.

**Mr. Chairman:** Could I just break in here? Obviously we're not going to get to Mr. Krasny and Mr. Bennett today. I'm wondering, Mr. Krasny, would it be possible for you to come back tomorrow first thing?

**Mr. Krasny:** Yes; what time?

**Mr. Chairman:** Approximately 3:15. Let me hedge that by saying it depends on how long question period goes, but between 3:15 and 3:30 if that is convenient for you, sir. I apologize for this, but it's one of those things that does happen sometimes. If that's all right, we can schedule you in at that time.

**Mr. Krasny:** Yes, it is.

**Mr. Chairman:** Now: Mr. Bennett, what about you, sir? Is it convenient for you to come back tomorrow?

**Mr. J. E. Bennett:** I'll do my best to make some schedule changes.

**Mr. Chairman:** Here again we do apologize for the inconvenience. Would it be convenient to put Mr. Krasny on first and then you in perhaps around 4:15 or thereabouts?

**Mr. J. E. Bennett:** I think you'll find that while different in some respects our views

tend to be similar; perhaps it would be most efficient for the committee if we went on together.

**Mr. Chairman:** Did a joint presentation? All right.

**Mr. Breaugh:** I was going to suggest, Mr. Chairman, that you simply split.

**Mr. Chairman:** Make a joint presentation.

**Mr. Breaugh:** I think that's an excellent idea; both witnesses could appear at the same time, make a brief presentation and answer questions; then at five o'clock or 4:45 we'll move on to the Lakeshore matter.

**Mr. Chairman:** Very good. Is that convenient, then, if we do it that way? Thank you very much. I'm sorry, Mr. Johnston. [6:00]

**Mr. R. F. Johnston:** I'm going to end with perhaps one thought about it. One might presume, looking at the international figures you gave us, that Canada was far away ahead in terms of preventative care and some of the lifestyle changes recommended today. Is that your feeling? Are those other countries which are behind us in terms of the number of beds per 1,000, are they dealing with preventative care that much better than we are?

**Dr. Smythe:** I think very few of my patients are diseased due to sin, but we do know that if we get early and effective treatment the later consequences are much less. Certainly in the field of arthritis, the proportion of our patients who are seriously disabled is very much less now than it was just 15 years ago. So, prevention in the form of care by early, intelligent intervention at the right time saves a lot of trouble later on.

**Mr. R. F. Johnston:** Has it been adequately funded? I mean we're getting cutbacks on acute care at the same time as we supposedly should be getting better preventative care.

**Dr. Smythe:** (Well I think that if you're talking about smoking—

**Mr. R. F. Johnston:** Yes.

**Dr. Smythe:** —and drinking and driving too fast, and indiscriminate sex and a few other of the risk factors, we don't need much medical research on that, that's been done. We know those are harmful and no government group and no medical group has really come up with an effective program to lower it. As far as effective early medical care is concerned, I think that is a concern of the North American medical community and the funding is variable. I think the mix of voluntary agencies and government funding has worked quite well. Perhaps the basic research

funding has not been so good, but in the applied research it has been not badly done.

**Mr. Chairman:** I should mention, and I don't want to sound like a broken record, but we have Mr. Ramsay, Mr. O'Neil, Mr. Sweeney and Mr. Pope.

**Mr. Ramsay:** Mr. Chairman, I only intend asking the question I was going to ask representatives of the Ontario Medical Association and on which I passed in the interest of time; these gentlemen are certainly equally qualified to answer that question.

But before I get to that, and it will only take a moment, I must refer to the fact, having seen Dr. Smythe here, that many years ago I was at a gathering at a time when your father had made a very unpopular decision here in Toronto involving the Maple Leafs, and I can't remember what it was but he was being severely castigated by the group in attendance until one gentleman, who was a physician of my acquaintance and from my home town, rose quite irately to the defence of your father by stating he had gone to university with you, knew you extremely well, and no man of the characteristics and compassion and qualities of Dr. Hugh Smythe could possibly have a father similar to the individual being described there that evening.

**Dr. Smythe:** Even your friend could be wrong.

**Mr. Ramsay:** To get back to the business at hand: The two presentations today were described by Mr. Johnston as a double whammy. I certainly admit, even being in the Conservative caucus, that they were very straightforward and excellent presentations, and certainly gave me, personally, an awful lot to be concerned about.

The thing that worries me, though, is that in the past number of days and weeks we've been listening to the problems and we haven't addressed ourselves—and I suppose we have to listen to the problems first—we haven't addressed ourselves to what the solutions will be. When we get gentlemen like those who were here earlier today, and you three who are here now, I feel it behooves us to ask your opinions in respect to these solutions. Is it increased taxes? Is it OHIP increases? Is it a cutback in some other ministries to provide additional funds for health care? Is it use of Wintario funds? I suppose the other question that I could ask you—

**Mr. Sweeney:** Those are political decisions.

**Mr. Ramsay:** Those are political decisions, I agree, Mr. Sweeney, and the gentleman who was up here earlier said that, but I'd just like to hear the opinions of these gentlemen,

if I may. I'm groping, I'm looking for opinions from all areas.

**Dr. Provan:** I'd like to comment on that, sir. I realize that in a sense it's not our prerogative to do this, but I left England in 1969 because at that stage, and I had worked in North America a little before that, the problems we're discussing today were very clearly apparent in England, in fact they were worse.

When I left England I was a consultant at an English teaching hospital, I had a waiting list of 120 patients, many of whom never had any hope of getting into hospital at all. This was purely because the system was underfunded. It has gone on being underfunded ever since and it's in bad straits today. For example, I gather there are now four administrators for every patient in the British health service. This is a situation that has concerned many people in this city. In one of the local teaching hospitals the medical staff has already raised questions about the number of people required to run this service.

I don't know how much it costs to administer OHIP; and I don't know whether you do, in fact, because we have extreme difficulty in getting that information out. I also sit on the tariff committee of the Ontario Medical Association. Our main concern is with this question of fees; trying to set fees that are equitable and fair for the services rendered.

I think that is a totally different question, and I think there is concern, it seems to me, in the minds of the ministry, to equate doctors' incomes with the cost of the health-care delivery system. Nothing is further from the truth. Sure it's one aspect of it, but when you think that it costs me \$200 a day to keep a patient in the Wellesley Hospital—and that's less than in many of the other hospitals I might add—that's where the major cost comes, it doesn't come in our fees.

But to answer the question you asked, all the things you mentioned are possibilities, and these are political decisions which it's not our place to question. It's my belief that in an affluent country such as Canada we cannot afford universality. We hear all this business about universality of health care. We've had universality ever since I've been here, and when I came to this country I thought what an excellent system it was. There were patients who were being treated for nothing.

I have, in one of my beds at the moment, a man who came to me from Jamaica with a pre-existing condition for which he cannot be covered in any way by OHIP. In discussions with the family the question of my fee kept coming up. My fee is minimal, but if that man stays in the hospital for 10 days



that's going to cost somebody \$2,000, minimum, and the stay is probably going to be longer than that.

We have to find some way of getting the money, and it's my belief the answer is private insurance, private money. Let's not confuse universality in terms of funding, with universality of access to health care, for some of the less advantaged members of our society, with removing their anxiety with respect to access to that medical care.

I believe that private money is the way it's going to go. I think this government has been in support of a private enterprise system, and I think in this sense this is what it should continue to do. Unfortunately, at the moment the opposite is happening. People donate money for capital equipment, which is desperately needed in various ways—and the CAT scanner comes to mind—but funds for continuing to run the equipment aren't available. I don't think the ministry is at all anxious to do this because of concerns about universality, I think that's the point I would like to make.

**Mr. Breaugh:** I wonder if I could put a supplementary question to Dr. Smythe, who is an expert in this field. What would Conn Smythe do if the Leafs were losing so badly the general consensus was they were stinking out the Gardens? What would Conn Smythe do; fire the team or fire the manager?

**Mr. Pope:** He's done both.

**Dr. Smythe:** Let's go back to your question. I disagree with my colleague on a number of the points we made. I think politics are very much our business and I think that health care is so much a concern of the people that the amount spent and the pattern of health care should be debated much more skilfully and much more openly, and I think much more in the press. What I've been—I don't want to undercut my professors, deans, chairmen, who are very reluctant to speak in the press, but I think that the resolution between Dr. Provan's position and my position, or other positions, should be done with open discussion, and I think it should be done with a long focus.

We had a very good system in 1972, we're both in agreement there. So some of the things we're talking about are a short-time result of short-time relative cuts based on short-term planning.

**Dr. Provan:** I wasn't trying to fight. I didn't think we had to have a voice in the political process. I do very strongly believe that. I just don't know that the decisions that are going to be made can be made by us. That's the point I wanted to make.

**Dr. Bean:** Mr. Chairman, I'm a transplant. I'm not a refugee. I'm the past president of the Saskatchewan Medical Association and I sat on the medical-care insurance commission in Saskatchewan for the first six years it was in operation, from 1962 to 1968. That was the body corporate. It was appointed by the Lieutenant Governor in Council and responsible through the ministry to the Legislature which tabled its report annually, and still does.

My friend and colleague, the late Ross Thatcher, who was as conservative as Bill, or at least as John Robarts, although he wore a Liberal label, introduced deterrent fees. At that point in time we did a study which was never published and advised him against it, because we said that the figures—and this was, interestingly enough, brought out by a recent study out of Carleton University published in the press—showed that the highest utilization per capita group in your society are the affluent.

University professors were the highest group in our study. But next were executives and management, and we said that a utilization fee would obviously not deter this group. It didn't. And the people who were indigent were well defined under the federal act so they would not pay any deterrent fees or utilization fees anyway. The only people who we were really going to hit were the people on fixed incomes and working poor, which were surely the ones we wanted to help, and this was subsequently borne out.

It was dropped, I suspected, as a political position. It did cost Ross the election. There were other issues as well, but that was certainly one of the big ones.

When one looks at the whole problem of utilization and over-servicing, it's so easy to cast a label and say, "You know, these darn patients come in with their cut finger because they can get a Band-Aid put on cheaper than it costs to go down to the drugstore," and, "These doctors are over-ordering, they are sanguinating them, doing their blood tests on them and so on."

Really there are two ends of the same stick. If you look at it, I can't quote these Ontario figures because I haven't got them, but they are still produced annually in the Saskatchewan report, and there have been about 20 to 25 per cent of the population who does not see a physician in any one year. Is this over-utilization?

There is another group that runs as high as between 35 and 40 per cent who use less than \$25 worth of medical care in any one year. This is over-utilization? And as you go up on the expenditure basis, it becomes a



relatively small group. It costs OHIP as much to pay a \$2.50 account as it does a \$250 account—I don't now what it costs them because there are no figures available on the cost of administering OHIP. I submit, even though as a family physician this would crucify me, that it's the two-bit things that are really costing us the money in the long run.

Surely in any insurance program it's the high-cost items we want to get covered. This is why we have \$200 deductible on our automobiles. And if you wanted to put it in, this is like providing first-dollar coverage on an automobile insurance program and then cutting off all of your body repair shops and saying, "No, there are only going to be so many available."

After having looked at it for many years, if I were going to pick something I would pick a system that has a deductible or which, in other words, put in some kind of a contractual agreement you come into me and I say, "Mr. Ramsay, I haven't seen you for a year and I think it's about time that we did a complete examination on you." So, we get a blood count, we get an X-ray of the chest and a cardiogram because, after all, you are in the age group at risk and your father died of a coronary and so on. You think, "Yes, that'd be a good idea." In order for you to have that done, you have to comply with my suggestion. That is doctor-operated.

[6:15]

On the other hand, you might come in and say, "Dr. Bean, I haven't had an examination for over a year and I am a little concerned about it, because my father died of a coronary recently. I'd like to have you do a complete examination and an X-ray of the chest and a cardiogram." If I comply, that is patient-generated. But in both instances you have to comply with my request and I have to comply with your request. If there is no deterrent, if there is no personal feeling of responsibility in there, then it's so easy for both of us to say, "Let's go whole hog and do them all." This is the decision we are faced with in our present system.

I don't know what the answers are; believe me, I don't. I know that it would be political suicide to come out with a \$25 deductible; labour would be down your throat, for one thing. On the other hand, you can make the case again, as Blakeney did in Saskatchewan, that the premium only pays 30 per cent of the cost of it; why should you be deprived of the other 70 per cent, at a time that this is only paying the 30 per cent? They wiped out the premium. I honestly don't know.

Again, on the hospitalization: Alberta probably has one of the best systems. They have kept it down to so much per diem when you go into a hospital, and it is a little less than the old age pension; then, when you go into a nursing home or a chronic-care institution, or what they call their auxiliary hospitals, you pay the same per diem rate, which again is less than the old age pension. They have structured it in as a staged care, as an extension of their hospitalization. These are some of the things that could be, but, again, as in politics, isn't it the art of the possible?

**Mr. Ramsay:** Thank you very much. The response of all three of you has been very interesting, and I thank you sincerely for it.

**Mr. Chairman:** Mr. O'Neil?

**Mr. O'Neil:** Mr. Chairman, I think some of my questions have been answered too.

I would like to ask, why is it that you went to the summer closings rather than closing so many beds during the year?

**Dr. Bean:** Basically because there seems to be a decrease in the utilization of hospital beds during the holiday season. We don't close them all over the summer months. This is the time when many of the population whom we serve take their holidays. They don't come in to see doctors; they don't want to get sick. The same thing holds true over Christmas. If you can possibly get them out of hospital for Christmas, over that season, you do it. This has been observed over a number of years, in a number of institutions; there has always been this move to get patients out for Christmas and New Year's if you possibly can. We decided to use this time and to close the 186 beds for the 81 days, split over the two holiday seasons.

Incidentally, it also enabled us to give our nursing staff—it took away the degree of self-determinism on when they took their holidays, but they took holidays at a time when it would be more acceptable to us, because that was also part of the bed-closure deal.

**Mr. O'Neil:** You mentioned some of the problems that you were having. I know you said that you sent these figures to the ministry and asked for confirmation of them; have you asked for meetings with the ministry or have you met with the ministry concerning your cutbacks on beds and some of the other suggestions you've made?

**Dr. Smythe:** Absolutely. I have given every possible invitation to meet with us further and discuss these matters further.

**Mr. O'Neil:** And have those invitations been taken up?

**Dr. Smythe:** Not as yet. But we haven't abandoned hope.

**Mr. O'Neil:** How long have you been trying to get these meetings?

**Dr. Smythe:** Formally, since April 4.

**Mr. O'Neil:** Also, Dr. Provan, you mentioned the private money. I wonder if you could expand on that. In other words, you are talking about a deterrent fee, in a way.

**Dr. Provan:** In a sense, yes. I wonder about private insurance. Blue Cross and Blue Shield were covering the situation very well for those people who wanted to be insured before. This, in a sense, gave some sense of personal responsibility to the people who wanted to insure themselves. It was working very well until the present scheme came in in 1970, or in 1971. I think that's a reasonable alternative which many people use, as Dr. Bean mentioned, for automobile insurance, house insurance and that sort of thing. I think it encourages people to take responsibility for their own health.

**Mr. O'Neil:** Mr. Chairman, I have other questions, but I think that's all now.

**Mr. Sweeney:** I have just two short things, one flowing from your very recent remarks. What you are describing seems similar to what they presently have in the United States. We all know they are planning or would like to look seriously at changing to something more akin to ours. What makes you think our switching to what they've got is going to solve any of our problems? We are just going to exchange one set of problems for another.

**Dr. Provan:** I am not quite sure why the United States differs from this country. I wondered about that recently. You may have read that big article which Time magazine had about health-care costs. They made the comment that one of the ironies of health-care delivery costs was the fact it was open-ended. Of course, what the present government is doing in this province is to make it less open-ended, which is a very good thing.

I think inflation has a lot to do with it and I think maybe we have been suffering more from inflation than has the United States. We seemed to manage it well in the 1960s and 1970s, maybe because of our own medical sense of responsibility. That might prevent this from happening in the way it has in the United States, but I find your question hard to answer.

**Mr. Sweeney:** During this period of time you say we were doing so well in Canada or in Ontario, were we not also in a period of

economic growth? Everything was going well. We didn't have the terrible educational financial problems. We didn't even have some of the social service problems at that time from a financial point of view. Is it really valid to the system per se, as opposed to having operated well in good economic times, that we are in trouble in bad economic times, however you define those terms?

I guess what I am concerned about is that you people are talking about long-term solutions. Are we maybe not reacting to short-term cause and effect and perhaps short-term solutions?

**Dr. Provan:** I appreciate your concerns and I think your points are well taken. I really don't know that I can answer them, but it does seem to me that when we have public money freely flowing, as we get in good times, then we get into some situations where people don't really mind where the money is coming from; it's government money, they are paying for it. We hear all the time that patients don't want to go home. I know this is unpopular with some parties but if patients don't have any stake in their care, then they will take it all the time.

I think it comes back to what I was saying about universality; I don't think we can have universality. Maybe my colleagues have something more to say.

**Mr. Sweeney:** We have some questions too, but it's just when we look at the alternatives, they don't seem to be all that hot either. There is no sense, as I say, in our exchanging one set of problems for another.

**Dr. Smythe:** I couldn't agree more. I want to express my rather different point of view, particularly because of my information in the field of arthritis care. I mentioned that early active intervention at the right time can make a tremendous difference to the outcome. We see this very much in comparing the results in Canadian medical centres with medical centres in the United States. I think a deterrent fee may deter the patient from coming at the time when things are easily dealt with. In most comparable United States centres they don't come and they don't get admitted until they have reached a crisis situation. I would hate to throw out the system we have had, which I think has been extremely good for at least this group of patients I know very well.

**Mr. Sweeney:** It's been suggested that since ultimately doctors make all the medical decisions which eventually end up costing something—in other words whether a patient goes in; how long they stay; surgery or no surgery; and medication—that if doctors toughened up



their decisions, we could resolve a lot of the problems. Obviously, you see that from a different perspective.

**Dr. Bean:** I laughingly tell my patients the definition of major surgery is if it's an operation on me it's major surgery. It's minor surgery if it's on you. This is perhaps said with tongue in cheek, but there are definitions of major and minor surgery both, believe me. But it's individual self-determinism. We advise surgery; whether they have it or not is yet a different thing altogether.

Even on the medicine—and, believe me, this is what we see in the outpatients, don't forget. Within the hospitals, they comply; they take their medicine or they get their injection. But once they get back in the community, our track record isn't nearly as good, even on the advice to drink less or stop smoking or don't do the things that are perhaps causing the problem.

It's a complex system, there's no question about it. I don't think there are any perfect answers.

**Mr. Sweeney:** Doctor, let me rephrase it slightly. Do you, as a doctor, believe you really are in a position to make considerable cost savings through the kinds of medical decisions you make with respect to your patients? In other words, whether or not they go in; how long they stay; what happens to them while they're there?

**Dr. Bean:** I think we do.

**Mr. Sweeney:** Is that a valid statement or is it not?

**Dr. Bean:** I think we do and I would certainly hope that the majority of us take this responsibility very carefully and very seriously, even down to the prescribing of drugs. I mean, I'll prescribe the drug that will "do the mosta for the leasta costa." Because why? I control the nation's drug bill. After all, they don't go out and buy themselves a handful of digitalis or something like this. This is a prescription drug. And I prescribe for them in my practice the drug that will do the most for them, to give them the greatest amount of relief.

The first thing I ask the drug retail man is, "How much does it cost?" I think the same thing holds true within the hospital system. And this was the reason I was saying it. Even with that high-risk group in St. James Town, we have got their expected hospital admission rate down to one half, which I think speaks reasonably well for it. I'm sure both my colleagues do this on their consultant cases, because I refer them cases. They say, "We can carry this one along as an outpatient." But what I'm saying in essence is,

by cutting back on the beds, don't put us in the position of having to play Russian roulette with patients. That's the thing I'm afraid of, to be quite honest with you.

**Mr. Sweeney:** I guess what I'm trying to suggest is, in fact it really is possible that if the kinds of decisions being made by doctors were as responsible as possible, then it wouldn't be necessary for us to make the kinds of decisions that we're being asked to make. In other words, we're being asked to make political decisions which, in fact, really are health decisions. We don't like being in that situation, but that's the name of the game.

**Dr. Bean:** Just don't demand perfection of us, either, because we too are finite beings.

**Dr. Provan:** I was just going to say the same thing. One of the things that is a fundamental factor is that if you take our budget of \$32 million or whatever it is at the Wellesley Hospital, 70 per cent of that is wages and labour. Very little of it, in fact, apart from the things you were talking about—drugs and instruments and that sort of thing—comes in the other 30 per cent.

**Mr. Sweeney:** Yes, but, doctor, if we didn't send people to that hospital you wouldn't need to have a staff.

**Dr. Provan:** I'm coming to that. There is an irreducible minimum. We've been looking into this in terms of a day-care surgery. We hear a lot about how much we would save. Well, sure you save. You save two shifts of nurses, or one and a half shifts of nurses probably. But there's a limit to what you can do and how many patients you see to do it. That depends on the sort of practice. If you work, say, in a community hospital you probably see more stuff you can do on a day-care basis than if you work in a tertiary-care hospital. And even then it may be not very much.

We're all worry doctors, all of us. We all worry. If your mother has something that's wrong with her, you want it solved. You go to a doctor; he's worried about it. This process goes on. A lot of the business of keeping people in hospital and treating them and looking after them and investigating them with expensive technology is a result of our anxieties to do away with worry.

[6:30]

I don't see ultimately how you reduce the cost of that worry. The CT scanner is a thing that comes to mind. That's revolutionized most of our practices in many ways and now, instead of us all worrying about it, we say, "Let's get a CT scan." That solves the



problem. It's expensive. Where does the community stop having to pay for that? I don't know the answer to that.

**Mr. Sweeney:** We want to remove all possible risk.

**Dr. Provan:** Well, indeed we do. That's what you want and that's what I want and that's what the patient wants. It's hard to keep everybody happy.

**Dr. Bean:** We will even live with the high-risk probabilities, not just possibilities. This is the thing that we look at, and don't think we don't.

**Dr. Provan:** Another point: Somebody mentioned coroners earlier this afternoon while I was listening. That's a major potential cause of keeping people in hospital because of the acute anxiety that we all share that we may be called up. For example, suppose the patient is to undergo anaesthesia now. When I was younger, we didn't bother very much that you used to get anaesthetized. Now you have to have all these done to them: electro-cardiograms; special X-rays, depending on their ages—the age limit is coming down all the time because the anaesthetist is not going to be put in the position of saying, "You didn't do this to this patient."

Nobody knows what the probability is. Certainly nobody's studied what the cost effectiveness is. But it's my impression that it's very inefficient in a costing sense. It delays surgery, delays the patient and it may save one life. Now we're talking philosophically. I don't know when it becomes a situation that you say, "Okay, we're not going to be able to afford this."

**Mr. Pope:** I'll be very brief. You indicate that you allocate operating space among the doctors, time-wise. Do you also allocate beds among the doctors?

**Dr. Provan:** No, we don't. There are I think six or seven divisions within our particular department, and each unit has a certain number of beds. The doctors themselves, at least in our institution, don't have a specific number of beds each; we do it on a share and share-about basis.

**Mr. Pope:** Have you heard of other institutions where they do?

**Dr. Provan:** It used to be done in Britain. This, in fact, encourages turnover of course, you see; which in fact is more expensive.

**Mr. Pope:** I just want to ask you, you wouldn't think of that as another form of Russian roulette.

**Dr. Provan:** Oh, yes.

**Mr. Pope:** I'm going to be very brief because you've been up here long enough. You have a special relationship with Grace Hospital to which you referred. Is that in operation now; and what's your referral rate to Grace Hospital?

**Dr. Bean:** From the time Grace was being planned as a chronic hospital we started to work with the administrative and the medical staff there to attempt to work out a system whereby those in need of chronic care would go into Grace as beds became available. Our social workers work closely together, it is a reciprocal deal. This is one of the things about chronic-care patients, they do get acute illnesses also and have to be hospitalized. So we will take their acute care patients if they get a flare-up they can't handle. Princess Margaret works closely with them in this respect as well.

**Mr. Pope:** How long has this been in effect, and has it helped?

**Dr. Bean:** Just since they opened their beds. I can't tell you the number of beds they have open now, but I think it's something in the order of 52 or so. They're planning to go to 125, which will work out, hopefully, to our mutual advantage. This has been part of the planning that's gone into it.

**Mr. Pope:** Do you expect it will shorten your average length of stay?

**Dr. Bean:** I can't answer that one. We also have beds at Riverdale, of course, which we use for the orthopaedic cases; they shift back and forth, but we get them out as soon as it's feasible and let them go as quickly as we possibly can. We also have a good department of rehabilitation medicine behind us too, which is worthwhile.

**Mr. Pope:** What are your occupancy rates for your different wards?

**Dr. Provan:** It's about 90 per cent; between 87 and 92 per cent.

**Mr. Pope:** Perhaps you could just send the committee the occupancy rates in the wards, and any data on average length of stay which you may have.

**Dr. Bean:** I'm sure we have. I was sorry that our executive director couldn't be here today. Unfortunately he is out of Ontario.

**Mr. Pope:** If you could get those figures we'd appreciate it very much. You refer to 60 per cent operating room capacity utilization as being the recommended standard according to the American system, have you seen any other recommended standards from any other system?

**Dr. Provan:** No, the figure of 60 per cent is the upper limit. Frequently, in special units, it's much less than that 30 per cent for orthopaedics and some other special units. If you're talking about a general operating room, 60 per cent seems to be the limit; but it's often less than that. Eighty-five per cent is way over.

**Mr. Pope:** You're a teaching hospital, have you had a dramatic increase in the number of resident doctors using your operating room facilities; or what accounts for operations being carried on until three in the morning?

**Dr. Provan:** In the past, when we had flexibility, we were able to fit those patients in during the day. If the room is empty, then we are able to take something that is an emergency. As I said, some emergencies have to be done immediately; others can wait a period of time but maybe can't wait till tomorrow. In the past we've had flexibility which enabled us to fit them in. The opening of this eighth operating room I was talking about, which had been held up not because of the bed closures but because of the financial shortcomings, has made a big difference.

**Mr. Pope:** What has been the increase in the number of doctors using your operating facilities over the last five years?

**Dr. Provan:** As far as surgery is concerned, I think there have been five or six new appointments to the surgical staff. These are not resident doctors, but they bring in work, of course, as they become known. After all, in a sense that's what they're there for. They have expertise which they have to offer the hospital and they get known for that.

**Mr. Pope:** Is that the reason for extending the operating hours; did that create the need to extend the operating hours?

**Dr. Provan:** Yes, partly. The other thing is that as we looked at the type of work that was being done, we noted that because of the tertiary nature of the hospital it tended to involve more complicated cases, cases that had been operated on elsewhere and now required redoing or reoperation, something had gone wrong. There was a rather greater increase in cases of this type, which take longer to do, of course, because they're more difficult.

**Mr. Pope:** Because of your own restraints, have you gotten into referral from your hospital to other hospitals in the Metro area?

**Dr. Provan:** We have, certainly. In the summer, particularly with acute surgery, this became a significant factor, as I said, in terms of teaching. The patients were coming in and

there weren't beds. In addition, it also affects the elective admissions. A patient expects to come in on a certain day, but finds his bed has been taken by an emergency patient who came in the preceding night and who can't be discharged. The answer to the question is yes.

**Mr. Pope:** If you can get them I'd appreciate the referral figures as well.

**Dr. Provan:** Referral figures? Yes, although I'm not sure that's very easy.

**Mr. Pope:** You refer to the minister talking about 15 per cent discharge or placement occupancy rating of beds.

**Dr. Provan:** That was a quotation from one of our administrators in response to a discussion I had with the minister.

**Mr. Pope:** Has that changed dramatically over the past few years, or can you place that in some context for us?

**Dr. Provan:** I don't know that one would expect it to have changed. I don't have those figures. They have been keeping an eye on that, because clearly that was a way in which more acute beds could have been obtained. But 15 per cent seems to be a fairly constant figure as I understand it.

**Dr. Smythe:** It has changed dramatically in our services.

**Mr. Pope:** Has increased dramatically?

**Dr. Smythe:** No, decreased.

**Mr. Pope:** Decreased, I'm sorry. Just one last question: What has been the change in your elective surgery list?

**Dr. Provan:** That's one question on which we are in the process of trying to find the answer. For some orthopaedic lists it runs at about two months, people are being booked two months ahead. In the summer, certainly, it becomes longer. Those are figures we are in the process of obtaining now.

**Mr. Pope:** Once you've completed them we'd appreciate receiving those as well.

**Mr. Chairman:** Thank you, Mr. Pope. Gentlemen, thank you very much for appearing before the committee and putting the problem before the group as you see it. We appreciate your time and we're grateful for your contribution.

Just one last question. I'd like to know when the Toronto Maple Leafs are going to win the Stanley Cup.

**Dr. Smythe:** Wouldn't we all?

**Dr. Bean:** Thank you very much for your gracious reception, Mr. Chairman.

The committee adjourned at 6:40 p.m.

### SPEAKERS IN THIS ISSUE

---

Breaugh, M. (Oshawa NDP)  
Conway, S. (Renfrew North L)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Kennedy, R. D. (Mississauga South PC)  
McClellan, R. (Bellwoods NDP)  
O'Neil, H. (Quinte L)  
Pope, A. (Cochrane South PC)  
Ramsay, R. H. (Sault Ste. Marie PC)  
Sweeney, J. (Kitchener-Wilmot L)

**From the Ontario Medical Association:**

Clarke, Dr. P., Staff Member  
Reese, Dr. L., Chairman of the Board  
Vail, Dr. W., Past President

**From Wellesley Hospital:**

Bean, Dr. I. W., Chairman, Medical Advisory Committee  
Provan, Dr. J., Head, Division of Vascular Surgery  
Smythe, Dr. H., Vice-President, Medical Staff

**From McKinsey and Company:**

Bennett, J. E., Consultant

**From Extendicare Limited:**

Krasny, J., Vice-President









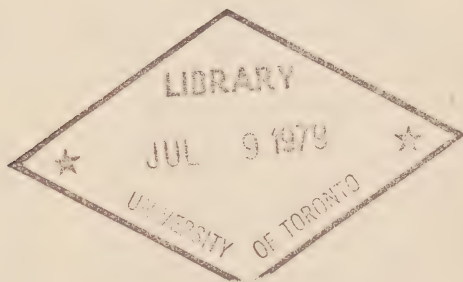
No. S-25

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Tuesday, June 12, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.



# LEGISLATURE OF ONTARIO

TUESDAY, JUNE 12, 1979

The committee met at 3:27 p.m. in committee room No. 2.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

(continued)

**Mr. Chairman:** I should tell the committee that the substitutes of which I have been made aware today are Mr. Lawlor for Ms. Gigantes, Mr. R. F. Johnston for Mr. Grande and the continuing one of Mr. Conway for Mr. Kerrio.

**Mr. Kennedy:** Is Evelyn Gigantes on the committee?

**Mr. Chairman:** Yes.

**Clerk of the Committee:** Mr. Lawlor and Mr. Breaugh are alternating.

**Mr. Conway:** Are you suggesting that Ms. Gigantes be brought in to participate, Mr. Kennedy?

**Mr. Kennedy:** No. I merely asked if she was on this committee.

**Mr. Chairman:** I think we'll call Mr. Bennett—I see Mr. Bennett has arrived—and Mr. Krasny. I understand that they wish to make a joint presentation. Mr. Krasny is with Extendicare Limited, I believe—

**Mr. Krasny:** That's correct.

**Mr. Chairman:** —and Mr. Bennett is a consultant with McKinsey and Company. Gentlemen, do you have any formal presentation to start off?

**Mr. J. E. Bennett:** No, we do not; just a few remarks that we might make, particularly reflecting on yesterday's discussion. As you know, we were sitting there during it.

**Mr. Chairman:** Right. Who wishes to start?

**Mr. J. E. Bennett:** Perhaps I could go first.

**Mr. Conway:** Just as a point of information, perhaps you could both tell us a little more about yourselves, your backgrounds and the kind of work you're engaged in. Some of us are familiar, but others are perhaps less so.

**Mr. J. E. Bennett:** I'm the managing partner of the Canadian activities of an international consulting firm called McKinsey and Company. McKinsey is basically a private-sector consulting firm serving large organizations. We also have, particularly over the

last three or four years, a practice in the health-care area dealing usually with policy issues or, if you will, major strategic issues in health care that are of concern to either institutions or Ministries of Health or the like.

[3:30]

We have worked in Canada in Newfoundland and St. John's. We have done some work for the Quebec Hospital Association. We have done several projects here in Ontario, one for the Grey-Bruce District Health Council on behalf of the council; another one, a recent one, with which I think the committee is familiar is the study of Lakeshore, Whitby and Queen Street Psychiatric Hospitals. Perhaps you've seen all or part of the report of that work. In addition, we have a very active health-care practice elsewhere in the world, including the United States. From time to time, we collaborate with colleagues from other offices on projects, either relevant to Canada or to other jurisdictions.

For example, about a year ago, Jack and I —Jack was then with McKinsey and Company—worked with colleagues in the United States on a project for health education and welfare, whose purpose was to distill from the Canadian experience, specific lessons on containing health care expenditures and doing effective health services planning that the US might take out of the experience in Ontario. In fact, we looked at four other provinces across the country as well. We have also done a fair amount of writing and speaking on, again, major policy issues relating to health care in Canada.

**Mr. Chairman:** Mr. Krasny.

**Mr. Krasny:** I am currently vice-president of Extendicare Limited. Up until several months ago I worked for Jim at McKinsey, so I won't dwell on that part of my career. Extendicare is the largest private sector health-care company in Canada. It has operations in Canada, the United States, and is currently negotiating activities in the Middle East, Africa and Europe as well. These have involved all forms of health-care service, such as nursing homes, home nursing, hospital management, laboratories, and so on.

**Mr. McClellan:** Is there a corporate relationship between the two organizations?

**Mr. Krasny:** It would be news to us.

**Mr. J. E. Bennett:** I think when the clerk of the committee called us and asked us to appear, she was under the impression Jack was still with McKinsey. We had written a series of articles, reprinted in the *Financial Post*, on health care in Canada, and they were subsequently bound together and distributed quite widely. Over the last several months, Jack has gone on to bigger and better things, leaving me behind. None the less, we have, I guess, many of the same points of view as we developed them back at the time of our working relationship together.

**Mr. R. F. Johnston:** Are you working on the Jerusalem deal?

**Mr. Krasny:** Not at this committee hearing, no.

**Mr. J. E. Bennett:** I have just one further point of background. What the clerk said to us, and why we, of course, were pleased to appear, was that we could be helpful to the committee by essentially answering questions that might be put to us, although on the basis of listening to yesterday's discussion I think a background comment or two by each of us might be in order so you know the point of view from which we begin.

**Mr. Chairman:** I think that would be helpful.

I am going to have to leave for approximately an hour because of some responsibilities in the House. I will be back in an hour and Mr. Sweeney has kindly agreed to take the chair. I wonder if we could agree to perhaps go to 4:45 p.m., at which time we would then move into the minister's report with respect to the transfer of inpatients from the Lakeshore Psychiatric Hospital. Is that agreed?

Thank you. If you wish to make an opening statement, Mr. Bennett, and then Mr. Krasny, please feel free.

**Mr. J. E. Bennett:** I have just three or four simple points that perhaps are worth making and would be of interest to the committee about our point of view. I think more than anything else we agree with the comments that were made yesterday that the essential choice to be made is what is an affordable level of expenditures for health care in Ontario. Everything starts from that essential choice. Once having made it, and assuming just for the moment the choice of what's affordable or what should be spent on health is less than is now currently spent, or that the rate of growth could not continue as in the past, it's my strong point of view that bed guidelines or a capacity limitation strategy, as implemented through bed

guidelines, is a very sensible way to go about making that lower rate of growth in expenditures come true.

I guess it's been our experience, as we have looked not only across Canada but around the world as well, that the most effective way to get a grip on health-care expenditures without hurting care levels or hurting care quality down to certain base-ment levels, is by capacity limitation. By that we mean slowing the rate of growth and the number of physicians in any jurisdiction, curbing the number or reducing the number of hospital beds available, and reducing the number of operating laboratories, et cetera; that is a capacity limitation strategy basically, because when health-care resources are there it's nearly axiomatic that they will be used.

The demand for health services, in our view, is virtually inexhaustible. Ontario or any other jurisdiction could absorb any amount of resources that we made available. The strategy of regulating capacity is one which is sensible because it gets the regulatory body, in this case the Ministry of Health, out of the business of having to regulate individual decisions on what will be charged for every single service, how it would be provided, et cetera, something of a mess that the United States is now in.

**Mr. Kennedy:** Could I just ask, on this bed capacity? Do you mean the 3.5 or some ratio?

**Mr. J. E. Bennett:** Yes, that's right.

**Mr. Kennedy:** Thank you.

**Mr. J. E. Bennett:** The question then becomes what's a reasonable ratio; for active-treatment beds in this case. Is it 3.5, is it four, is it two; or what might it be? I think the answer to that, as several gentlemen commented yesterday, is that nobody knows for sure. However, there are some numbers which I think provide useful perspective and which suggest, at least to me, that 3.5 is not an unreasonable limit or floor to try to work to.

To give you a few numbers in Canada by way of comparison, assuming I have them correctly here, Quebec's active-treatment guideline, the comparable number to the 3.5, is now 2.4, or at least it was about a year ago.

**Mr. McClellan:** What's the source of that? It certainly doesn't jibe with my recollection of the OHA's, or the ministry's comparative figures.

**Mr. J. E. Bennett:** I am just taking it directly from the work we have done for HEW, in which we spent a substantial amount of time in each of five provinces;



Ontario, Quebec, British Columbia, Alberta and Saskatchewan. I am taking it directly from our numbers there. The source was the Ministry of Social Services in Quebec, on the spot from having been there and talked it through with them.

**Mr. Kennedy:** That's active-treatment beds?

**Mr. J. E. Bennett:** That's active. Let me give you some total numbers. I know figures are always confusing, but if you add up acute care, rehab and chronic care, the current Ontario number, as I understand it, is 4.8; that is 3.5 for active treatment, 0.2 for rehab and 1.1 for chronic care; unless it has recently changed. So that's 4.8. The Quebec number by way of comparison is 4.2. That's 2.4 in active treatment, 0.3 in rehab and 1.5 in chronic. So they show a rather greater emphasis on chronic care in the overall bedding levels.

BC is 4.25; Alberta is five, or was a year ago; Saskatchewan is 7.3, primarily because, as they describe it, the much greater geographic dispersion they have to cope with—that is the equivalent of Ontario's 4.5 for northern regions.

The general theme is that while there is no number that any of us could say is exactly the proper one, it's the most sensible arbitrary one. We see no evidence that 3.5 is an unreasonable number. Other provinces in Canada work on numbers as low as that, or lower in the total beds available in hospitals. Beyond that there are other experiences, such as health maintenance organizations in the United States, for example the Kaiser Plan, where something in the order of three active-treatment beds per 1,000 population is the number they would work to.

So if you start from the proposition that a capacity-limiting strategy is a good way to go about it, which is my view, there is nothing particularly—the 3.5 does not seem to be pushing it to the level that is unreasonable. It then boils down to a number of considerations regarding implementation.

I think the doctors who were present yesterday made a number of points about how implementation of the guidelines had affected their own particular situations. The kinds of things that matter in implementing them are the proportion of elderly in the particular catchment area, or the referral population served by that institution or group of institutions. As I'm sure you are well aware, people over age 65 can require 11 or 12 or 13 times as many inpatient days as individuals in their 30s or 40s. So even several percentage points more elderly population will mean that 3.5, or any number, has to be adjusted up-

wards. It's our understanding, by the way, that the ministry's guidelines do provide for doing that, as they are age-adjusted for individual referral populations.

One thing very important in implementation is the number of elderly people. The second thing is the availability of chronic beds, and I'm sure you've heard that many times before. It doesn't do too much good to talk about 3.5 for active-treatment beds without making sure at the same time that 1.1 beds, or whatever number is judged appropriate, are in fact available. Otherwise, chronic patients end up in that 3.5, and the actual working level from the 3.5 for active treatment is much lower; say, below three or in the high two's, getting down to levels which really are very tight.

**Mr. McClellan:** May I ask for clarification? I would like at least to have the data base you're operating from clear in my own head. I may have misunderstood; so I just want to be clear. The figures we obtained from the Ontario Hospital Association, which are Ministry of Health figures of hospital beds per thousand, as of March 31, 1978, show Ontario with 4.63 active-treatment beds per thousand and Quebec with 4.67.

**Mr. J. E. Bennett:** Guidelines or actual?

**Mr. McClellan:** There are active-treatment beds staffed and in operation as of March 31, 1978.

**Mr. J. E. Bennett:** I'm sorry; I was referring to the guideline—the equivalent of the 3.5, or 4.8 overall in Ontario.

**Mr. McClellan:** Oh, I see. So you're talking about Quebec's current guidelines, taken in the context of a health-care system that relies much more on community health services than the Ontario system.

**Mr. J. E. Bennett:** Right. If a comparable committee were sitting in Quebec, the debate would be not over a number like 3.5 but 2.4. So it's the guidelines I was speaking of. The actuals are always moving, generally downward in Canada these days.

**Mr. McClellan:** I thought you were talking about actuals.

**Mr. J. E. Bennett:** Sorry for the confusion. But in short—and I hadn't intended to speak this long—I do think that having bed guidelines in general and negotiating the specifics is a good and sensible strategy for health-care cost containment, and one which can be achieved, if the guideline is at the correct level and properly implemented, without damaging the quality of care.

A guideline of 3.5 does not seem unreasonable to me as a level to be working towards,

and it all then boils down to a question of implementation as it applies to particular areas or institutions. I have no view on how well the ministry has handled that implementation as it deals with Metro Toronto, Windsor, London or any other jurisdiction. At least if I have one I'd rather keep it to myself.

**Mr. Acting Chairman:** Before we go to questions, Mr. Krasny, do you have any comments that tie in with that?

**Mr. Krasny:** I'd just like to amplify some things that Jim Bennett has said. The first thing I'd like to add is that the debate which this committee is now entering, and which is now going on about constraints for health-care costs, is not one that is going to be resolved. It's not going to happen this year and end; it's going to be ongoing, I'm afraid, for the foreseeable future. The demand for health care will continue to increase with the ageing of the population and with advances in technology, and resources will continue to be constrained.

Given that, it's my feeling the government has only one of two options or types of ways in which to resolve that situation: To set overall broad guidelines of some sort, and then allow the practitioners, the physicians, to decide on priorities; for that reason I endorse the use of a guideline, be it 3.5 or whatever number. Or, alternatively, to set some specific standards, such as those for CT scanners. The latter, I don't think, is a good approach in the case of CT scanners and other methods. For that reason, my feeling is the ministry is taking a proper and sensible approach in this regard—just to add to what Jim has said.

[3:45]

**Mr. J. E. Bennett:** May I make one more comment, and then I will cease speaking. In various speaking appearances in interaction with hospital administrators and physicians across the country, I have been struck by the problems they are having with morale in individual institutions. It has seemed to me that is totally and completely to be expected from both the system and individual institutions that had been used to a growth pattern, basically in a building mode, for the last 10, 15 or 20 years in some cases. If we look at a corporation in the private sector, for example, we see the way Air Canada has grown and grown up to 1970 and the terrible time it is having in adjusting to lack of growth, more competition and so forth.

It seems to me that the turbulence and the anguish we are seeing on the part of health-care providers, provided through very

powerful anecdotal evidence, are all genuine and real but totally to be expected as institutions shake out and make a transition into a new environment. I would be very surprised if there were not a great deal of pain in making transitions, because no organization of any size—no group of human beings—makes them very easily. They are very difficult things to adjust to.

On the one hand, I guess I would be sympathetic to—and feel that it's genuine—everything that this committee has heard about the problems that individual providers are having at that very micro level. On the other hand, from the point of view of the overall health-care system in Ontario, I think personally that expenditure containment is necessary, and that the strategies being followed, one of them being to implement bed guidelines, are correct.

I don't see an inconsistency between the difficult times that individuals are having and the concern that individual physicians feel for their patients and, on the other hand, the need to put in mechanisms that will bring down the growth in expenditures.

**Mr. Acting Chairman:** Very well. I have four people on my question list now, in this order Mr. Conway, Mr. Johnston, Mr. Kennedy and Mr. McClellan. We'll start with Mr. Conway.

**Mr. Conway:** Gentlemen, I appreciate your being here. I well remember my first introduction to you was the Financial Post series, which left me with one or two impressions that I'd like to explore with you very briefly. My recollection of that series of articles is that you said in one place that our ageing population was "the time bomb" of this health-care system. That is a fairly obvious comment. Do you see much being done in the institutional sector, subsequent to your observations a year or two ago, that would make you believe this bomb is being disengaged in any way?

**Mr. J. E. Bennett:** Not from my point of view.

**Mr. Krasny:** I don't think there is any way to disengage this bomb, short of finding a way of establishing immortality. People are continuing to age, and the simple fact remains that the need for health care is proportional to age, certainly beyond the years of 50 and 60; that is not changing.

What has happened as a result of the articles is there has been a realization that the pressures being felt by hospitals and practitioners are not a temporary phenomenon but will continue, certainly in Canada, for quite a time to come.



**Mr. Conway:** Would you indicate your views about the sorts of readjustments—conversions, if you want—that are required in a system that is facing this sort of increasing pressure from an ageing population? Are those conversions, such as the minister has described them, taking place with any kind of frequency and effect that you would see as necessary? Are we readjusting this system institutionally to meet those growing needs sufficiently?

**Mr. J. E. Bennett:** Not sufficiently, in my view. But it never could be. It's very slow and painful, yet none the less taking place. I don't mean to be evasive, but I reflect on meetings of hospital administrators even two or three years ago, where we were invited speakers, where the very thought of expenditure containment and some of the things that are now common vocabulary, in this committee and with the people who appear before it, were unthinkable.

In terms of change of attitudes and the realization that the system has been adjusted, there has been quite a shift in the province in the last two or three years. In terms of tangible accomplishments, there is yet to be a great deal that can be proven from that attitudinal change. I am reasonably optimistic that they will follow. But it's a slow and painful working out that may take eight or 10 years.

**Mr. Conway:** Like a lot of experts with great expertise in a field, there are certain phrases which I hear from you that I would like to pursue a bit. One is—and you used it here earlier this afternoon, you had suggested that proper guidelines and control of capacity for the reasons you give, which I tend to agree with, are a worthwhile public policy so long as proper implementation is proceeded with. Could you identify for this committee, or for me at least, some of the corner-stones, or some of the more basic fundamentals of “the process of proper implementation”?

**Mr. Krasny:** The irony of it is that it would not—and this is a personal opinion—be hallmarked by smooth and genuine accord on the part of the community. I think a process of proper implementation, one that is cutting down on resources and seeking to establish new priorities, would be typified by exactly the kind of difficult debate and argument we now see going on. I don't think we are viewing anything wrong happening any more than one can criticize our parliamentary system because it seems to have such a great deal of argument in it.

**Mr. Conway:** Gentlemen, are you reasonably suggesting to me that the most identi-

fiable criterion for a process of proper implementation is the sort of parliamentary debate that you're witnessing here today?

**Mr. Krasny:** No, I don't think that is the sole hallmark. On the other hand, I think a situation where one is trying to cut back on resources in an environment where people have not been used to that kind of situation will almost inevitably result in tensions in that system. As long as the government, on the one hand, in trying to cut back resources sticks to its basic guidelines and they are reasonable—and as a personal opinion I agree with Jim Bennett in terms of the 3.5 guideline being reasonable—and as long as the other parties seek within that limit to modify the way they use those resources, I'm content that the debate is profitable.

**Mr. J. E. Bennett:** Mr. Conway, could I add another perspective to that? It would seem to me, by and large from the top of my head, that the kinds of things that would strike me as characterizing proper implementation go something like this. First of all, if the ministry is clear in its own mind on the basis for wishing a certain number of bed reductions in a certain referral population, based on a real understanding of how health care is delivered and the needs of the people who live there—that is having to do with the age of the population, the demand on institutions, the mix of secondary and tertiary care and the like—if it comes forward with that information in hand and says: “Here's the way we see it and here's what we think it tells us in terms of bed reductions”; and if in turn the people who are affected by that—leaving aside the nuances among the medical profession, the hospital administrators and boards and the district health councils, because that is a complex and confusing overlapping of interests—have an opportunity to take whatever shots, to argue as hard as they can to attempt to change the ministry's mind; if that kind of animated and likely heated and emotional debate and interchange that this is going to provoke takes place so that a decision is then made through the funding mechanism as to how it will be accomplished, my own vote, again starting from the imperative to spend only a certain amount on health care, would be that after having had that back-and-forth debate, the funding decision stays with the funder.

**Mr. Conway:** I am really trying to lead you to a commentary on the role of casuistry or the regional local considerations when you are talking about general guidelines. You indicated that you had done some work for the Grey-Bruce health council. Am I incorrect



in recalling or remembering that in that particular study you identified an appropriate bed ratio that is somewhat above the one proposed by the ministry?

**Mr. J. E. Bennett:** You are correct, and it was above. In that particular case, having attempted the closure of Chesley and Durham, the ministry then said to the community through the district health council: "We'd like you to go ahead and tackle this, and then come back and tell us what you think you ought to do about those 11 hospitals, 13 nursing homes and four homes for the aged up there, with particular concentration of hospital beds." The council was given a budget by the ministry to do its own work and analyse the situation, and they asked us to help them do that. Starting from the 3.5, we ended up with a number which was at least a full bed higher, based on the very much greater proportion of the elderly that live in those two counties and based on a fairly careful analysis of the mix of various kinds of care, the longer adjusted lengths of stay for the more complicated care done in the Owen Sound hospital. We came back with 4.5 and said, even with that 4.5 it looks to us as though you're now at seven; you still have, as a community, some beds that you've got to get out of there if you're going to do what is sensible and move toward the provincially-established guideline, but it's a different number for you. Then it was tossed back to them to deal with as a council.

**Mr. Conway:** As experts in the field more recently involved in that particular area, you found good and sufficient cause to recommend to the health council that an appropriate active-treatment bed ratio, given all the local considerations which you've just outlined, was not 3.5, was not four, but was in fact 4.5.

**Mr. J. E. Bennett:** For those two counties?

**Mr Conway:** For those two counties.

**Mr. J. E. Bennett:** Yes.

**Mr. Conway:** My point to you is that was one area with one health council. As a policy maker I represent, in my own parochial interest let us say, a region of rural eastern Ontario which has the added burden of non-resident pressure from the province of Quebec, a region in west Quebec which is not well served by the Quebec City government which is many miles away. So we have that non-resident factor together with many of the things you have indicated above. Why would I not believe and suggest to my local community, that the same possibility is not in fact there in my area? That really, what we should do is engage Bennett and Krasny to

come here. I am sure, I would bet what little money I have, that probably you would be able to conclude that in Renfrew-Lanark 4.5 is not an inappropriate guideline. I guess what I'm saying to you is that how much of this province-wide bed ratio policy could we subject to that sort of intensive local examination on the one hand, and on the other hand produce a whole series of footnote exceptions, the exceptions then becoming the rule?

**Mr. Krasny:** I think it's worth pointing out that in the case of our analysis the logic we apply to the Grey-Bruce situation, the 4.5, or the number that resulted, started off using what was then the government guideline of four. The modification resulted from what is analytically probably the most important weakness in the government's referral pattern calculation. It was mentioned yesterday, the use of discharge or admission date as opposed to patient-days. But the cornerstone of the analysis was the government guideline. We accepted that for the same reasons we're presenting today. We did many analyses dealing with traffic patterns, tourism, marriage rates; and sought to find reasons why the population of Grey-Bruce was for some reason exceptional. We could not find any that justified having more beds. The only major issue was use of the Alexandra Marine and General Hospital in Owen Sound as a secondary referral centre, and the adjustment was for that reason.

**Mr. J. E. Bennett:** The higher proportion of elderly was the second thing that fitted in there. Your point, though, is well taken. I think it goes to the implementation process. The ministry says this is what we are trying to achieve. Here's what it says for your particular area. The area comes back and says: "We don't think we can get the whole thing. We think it ought to be somewhat higher, but we'll meet you part way." My view is that that's the way the process ought to work. It's a negotiation process: if you start with a number that's at 4.5 what you'll end up with is 5.5. If you start with something that's reasonable, but lower, and keep the pressure on, you'll end up, as implementation works its way through, with something that gets a heck of a lot closer to a more sensible number. I'm not suggesting, and I have no reason to think, that what the ministry is looking for is four. But I would view it, by what you say, as part of the negotiation process.

**Mr. Conway:** That's my next point. What I'm suggesting, and I think you've basically agreed, is that in a province as disparate and as regional as this it's not unlikely we're

going to find those local situations. You've identified Grey-Bruce. I believe some members here would privately, if not publicly, admit there are other examples of the same thing.

[4:00]

For argument's sake, if we do accept at least the need to adopt a policy of some restraint and reallocation within that policy, I want to know if we can devise a more appropriate appeal mechanism or a more appropriate adjustment mechanism than this situation; where you hopefully have a board and an administrator and a local member, and God only knows who else, who feel very strongly and aggressively about this and approach the ministry for a private consultation, out of which may very well come an ad hoc readjustment. What I'm asking is, is there no more systematic way of dealing with the inherent casuistry of a regionalized province like this?

**Mr. R. F. Johnston:** Inherent? What do you mean?

**Mr. Conway:** The idea that you're going to have to make judgements on the basis of local conditions and so on.

**Mr. Kennedy:** Could I just put a supplementary question? You just came up with a basis of four or 4.5 in this area. By the same token, is it possible that you could come up with three or 3.5 or some other figure?

**Mr. Krasny:** Something that has to be kept in mind, and that is that about the only way in which those numbers change was a different mathematical approach to the use of the referral patterns. Ultimately, in the way in which those numbers are calculated, there are a finite number of beds in hospitals in Ontario, there is a finite population, and the calculation only serves to divide the population of the province among the hospitals. In the case of Grey-Bruce, and particularly the Alexandra Marine and General Hospital at Owen Sound, that did raise it upwards. The same calculation, by definition, must have reduced it in other areas where at the time, as consultants, we weren't mandated to look at. But ultimately it apportions the population across the hospital beds, and no more than that. It shoots to the four overall guideline at that time.

**Mr. J. E. Bennett:** The answer is that in a heavily urbanized area, depending on referral patterns, driving distances and things of that sort you could well come to the conclusion—not if you were doing it from an advocacy point of view but simply trying to make all the numbers balance out to a 3.5—that it

ought to be below the guideline, that is below whatever number is chosen. If the number is 3.5, then the appropriate number for that area is three, as Jack is saying.

So the answer to your question is yes. We always give long answers here.

**Mr. Kennedy:** It's maybe a supplement to the supplement, but how far afield should you go in setting these criteria; for averaging purposes if you like?

You did two counties. Should you do Metro? Should you do one hospital area? Should you do six counties to come up with a guideline?

**Mr. Krasny:** At that time the guideline was four. We did not, in the course of the study, suggest the guideline be otherwise. What we did suggest was the application of a four guideline in that jurisdiction, for one reason only. (We thought the inadequacy of the use of the discharge pattern in calculating referral patterns should reflect in a different number for that community, and it involved only one hospital of the several in those two counties. The same method applied elsewhere would adjust allowable bed factors up and down, but would not have changed what was then the four guideline, would not change what is now the 3.5 guideline, only its specific application to individual hospitals.

**Mr. J. E. Bennett:** But in terms of the blocks of planning units, the units to which that might be applied, I would think there is no right answer. I would say that the comment made yesterday, by Dr. Smythe I believe it was from Wellesley, that the impact on Metro Toronto of people from out of the area is very important to consider. Still, I think Metro Toronto is a reasonable unit to be looking at. Similarly, I think the Grey and Bruce counties together were pretty good. We found there was a lot of overlap with Dufferin, as I recall, and since the district health council did not have Dufferin within its area that was a little awkward around the fringes.

But there will never be any ideal units. I think they ought to be manageable, and the district health council jurisdictions are probably as good as any for having that negotiation.

**Mr. Conway:** The final question I want to put is this, Mr. Chairman. It seems to me one of the difficulties we have experienced over the course of this particular discussion, as well as one that took place in the select committee on health care costs and financing last summer, was the recognition of the need to make some adjustments within the hospital institutional sector, recognizing the strength and



the extent of the industry which is built up, which you did draw some attention to.

There obviously has to be some inducement, some carrot, some incentive provided. Can you carry this committee more forward than others have been able to in outlining the sorts of incentive you introduce into a system which is undergoing the kind of readjustment you've described? Are there any easier or not so easy means by which we, as policy makers, could induce people who are well above the active-treatment guidelines that are going to be established, to bring them down and to make them participate more happily in that process?

**Mr. Krasny:** I think the direct answer to your questions is I don't think there are any easy, positive incentives in this kind of a system. I think the other important aspect is something you said in terms of being policy makers. We had the comfort, when we were doing health-care studies, to say we will look exclusively at the health-care aspects of these decisions. I think you, as a legislator, must take into account the impact of small hospitals as employers in small communities, the culture and the pride that has been established in building those hospitals, the interaction of the community with that organization and what it provides to that community. Those are very difficult trade-offs. There are, in my opinion, no easy answers in that regard.

**Mr. Conway:** In your studies of Ontario and other Canadian jurisdictions, how much evidence have you come across that a lot of the institutional sector was the result of politicians anxious to cut ribbons in places where perhaps they should never have been thought of in the first place? I'm one who believes there was a substantial amount of that done in the 1950s and 1960s, but I've got nothing other than a bit of anecdotal evidence to suggest it's true. Is it something that's by and large not the case? Are patterns of rural de-population much more likely to explain the need for adjustments?

**Mr. J. E. Bennett:** My evidence is largely anecdotal as well. My clear impression is because of the way in which hospital insurance preceded reimbursement for medical care, that in—the dates escape me but I guess in 1959 and 1957—there was really quite a spate of hospital building because the money was there to do it and it was a matter of community pride to have an institution. I don't know that it was so much the desire for ribbon-cutting, although that's part of it; but it was the availability of the financial incentive to go ahead and build a hospital,

plus the pride of the community in doing it and the consequent, I guess, pride an elected representative would take in helping make it happen. I think in general that explains the situation where there would be three or four hospitals within 10 or 12 miles of each other in Grey and Bruce counties. It did not have to do with a logical pattern of providing hospital base care.

**Mr. Krasny:** I would just add that I think there was a prevalent belief at that time, and nobody was arguing to the contrary, that one could not have too many hospitals, or too many beds, and that adding physicians and hospital beds and other forms of care to a community could do nothing but good in terms of providing jobs and assisting the people of that community. In many cases it was religious organizations, schools as well as local, provincial and federal politicians, which were the instigators in establishing more hospitals.

**Mr. Conway:** Finally, my impression has always been that perhaps we overbuilt the new Hanover and District Hospital at a late date, which ultimately brought the requirement to close some of the then unnecessary beds or facilities at Durham Memorial Hospital and Chesley and District Memorial Hospital. That's the sort of paradigm, the example, I had in the back of my mind.

**Mr. J. E. Bennett:** That's an example that's often put forward. We did not look at that specifically to see why it had been built, but it's one that's frequently put forward as an example now.

**Mr. Acting Chairman:** Mr. Johnston.

**Mr. R. F. Johnston:** I did have a question or two, but I think I will defer if I might, and ask Mr. McClellan to carry on in my stead.

**Mr. McClellan:** I have a couple of questions. Given your assumption of the need for expenditure constraint and your prescription that bed guidelines are the way to achieve that, we remain in a dilemma around the development of the particular guidelines in this particular province. If you were given the contract by the Ministry of Health to develop an appropriate guideline for the province of Ontario, how would you go about doing it?

**Mr. J. E. Bennett:** I would decline to accept that contract. Speaking for McKinsey and Company, and I'm able to do that since as I say I run the office, we'd decline that because I think it's essentially a political judgement. You ladies and gentlemen understand far better than I do how the political



process works. My impression is that the amount of money that's available to the Ministry of Health, as it jostles with other social services and other provincial priorities, is an important factor that shapes what is a sensible bed guideline as much as anything else. I don't think analysis contributes a lot by way of a problem-solving approach. I think I'd be more content to come in for a couple of hours and give my opinion on what's a sensible guideline rather than undertaking an assignment to try to develop it. I don't think it's possible.

**Mr. Krasny:** If I might just add to that: both of us had the rare opportunity yesterday of listening and not testifying. While listening I had the opportunity to put myself in your shoes as a committee. One of several eloquent statements I heard was to the effect that a hospital in London, Ontario, was in deep difficulty with its obstetric unit at 95 per cent utilization; but the same fellow said quite clearly one of the factors in it not being at 100 per cent was that people in that hospital did not like to work on week-ends. Nearby Tillsonburg was at 25 per cent or 26 per cent occupancy.

I was thinking if I were a committee member I would be wondering as to whether or not the citizens of Ontario were deriving proper value for a very expensive capital investment if people were allowed or were indulging themselves in not working on week-ends if that was what they didn't want to do. Certainly many other industries in this province normally work three shifts a day, seven days a week when the pressures are on. Similarly, I think it's something of a luxury to be able to allow people to select, through their physicians, which hospital they'll use as opposed to others that stay vacant. I don't think that's wrong, but those are the kind of trade-offs that you, as a committee, have got to make. I think those were two specific pieces of evidence that indicated that a very small microsystem which appeared to be at capacity was in fact not at capacity.

**Mr. McClellan:** Right; but you can run three shifts if you have the funds to pay for three shifts. Isn't that as much a dilemma as the ratio question?

**Mr. Krasny:** There are two sets of guidelines involved. There are the budget guidelines and there are the bed guidelines. The difficulty is that they have to be dealt with somewhat separately.

**Mr. McClellan:** It struck me, if I can be more precise, they were in a real catch-22

situation. They had the choice of underutilization, but they didn't have the funds to bring on additional staff for more effective utilization so the only thing they had facing them was the option of stretching their existing staff complement to the breaking point. That's what I understood was the dilemma they were presenting to us. You may have taken a different interpretation, in which case I'd be interested to hear it.

**Mr. Krasny:** I don't suggest for a moment that what they presented was inaccurate. I think the perspective I was trying to take, though, was not so much from the point of view of the management of that hospital and its obviously very intense attempts to make do with limited staff and budget and provide a great deal of service. Rather, if one took the reverse role, and thought about what was best in terms of the utilization of resources for the people living in the areas in and around London, it struck me that here was a facility utilized part of the time and not other parts, and there were nearby facilities that were underutilized.

**Mr. McClellan:** Surely then this brings us back to the beginning of our question about how you go about developing an appropriate ratio. I suppose another way of putting it is when is a guideline a guideline and when is a guideline a standard? I don't know if you make a distinction. Do you perceive the guideline that's being imposed by the ministry this year as a guideline, or do you see it as a standard with which people are required to comply?

**Mr. J. E. Bennett:** My own perception was that it was a guideline and basis for negotiation. That's perhaps shaped by the Grey-Bruce experience which I described earlier. I think it goes back to the supplementary question asked by the gentleman earlier. Whether it's a guideline or standard has to do with what's the relevant unit to apply it to. We took a fair amount of care in the Grey-Bruce situation to construct catchment areas, which are not things that are routinely constructed. The way we did it was to take the various referral populations of the institutions and overlap them from a geography point. We found some interesting things about where people went.

[4:15]

**Mr. McClellan:** Surely that should be done in each and every regional area. If you are operating on a guideline system, which presumes a process of negotiation with respect to fitting square pegs into round holes, then accompanying the guideline process there should be a process of regional examination

to determine the applicability of the general guideline to the particular area.

**Mr. J. E. Bennett:** Yes, to put the point more precisely and the other way around, I think that to look at an individual institution and to apply the guideline to the individual institution is not correct. What is correct is to apply the guideline to a catchment area which may have one, two or three institutions in it, depending on how it happens to be located.

**Mr. McClellan:** Secondly, you should understand what's happening within the catchment area.

**Mr. J. E. Bennett:** That's right.

**Mr. McClellan:** You are assuming a process of rational planning within each catchment area that we don't see; that's our dilemma.

**Mr. J. E. Bennett:** The information is available to do that. It is not something which requires a particularly creative or wildly industrious data gathering effort. It does require the ability to look at it on more than an institution-by-institution basis. That has to be done, I would think, by the district health councils looking at it from their perspective, and then the ministry looking at it from its perspective.

**Mr. McClellan:** When we were on the question of what is the proper ratio and how one establishes the guideline—and we've heard the expression pulling the figure out of the hat—you expressed some approval for the 3.5 guideline on the basis of experience in other jurisdictions. You cited the Quebec example. I think the figure you used was 2.9.

**Mr. J. E. Bennett:** I think it was 2.4.

**Mr. McClellan:** How was that applied? Are you familiar with how the Quebec equivalent of the Ministry of Health deals with its guideline in relation to individual hospitals or health regions?

**Mr. J. E. Bennett:** I am personally not as familiar as I was when there was a Liberal government there instead of the PQ. By and large it's much more directive-oriented and centralized—sorry, centralized isn't quite the right word. By way of comparison the ministry takes a stronger prescriptive role than is the case here. We are very clear on that from our work with the Quebec Hospital Association in getting to know a number of the institutions there. By and large they are much more Draconian, if I could use that word, in withholding funds for those areas which are not judged to be in compliance. According to the governmental culture—at least in social affairs as it was a combined ministry—the way of dealing with local areas

is not to encourage negotiation and dialogue but rather to prescribe. It's much more of a prescriptive kind of view in my impression. That is not an up-to-date one, it's a year old at least.

**Mr. Turner:** Mr. Chairman, may I ask a supplementary?

**Mr. McClellan:** I think there was another answer to come. Then feel free to ask the question.

**Mr. Krasny:** I don't have another answer but I would like to add something to what Mr. Bennett has said. The approach in Quebec is exactly that way. One of the things that is important here is to keep in mind that budget guidelines for hospitals are one aspect of the health-care systems. Beds don't treat people nor do hospitals; they are simply a marketplace where physicians and other medical personnel come together with their patients.

**Mr. McClellan:** And there's much more use of alternative facilities included.

**Mr. Krasny:** There can be. In Quebec they sought to acknowledge that in a very direct fashion. They created what they call CRSSS, which encompasses all the health and social services. For example, they define these regions rather differently than Ontario defines district health councils in that they cut across most political jurisdictions.

**Mr. McClellan:** They advise me we have three minutes before the vote.

**Mr. Acting Chairman:** We vote in three minutes or leave here in three minutes?

**Mr. Warner:** Nothing is ever sure!

**Mr. Acting Chairman:** I think we'd better go. Before we go, Mr. Turner, can your question hold until we come back?

**Mr. Turner:** Sure.

**Mr. Acting Chairman:** Gentlemen, would you remain?

**Mr. J. E. Bennett:** How long would this likely be?

**Mr. Acting Chairman:** You are welcome to come up with us and see for yourselves, but we'd like to continue this after.

The committee recessed at 4:19 p.m. for a vote in the House.

On resumption:

**Mr. Acting Chairman:** Mr. Kennedy and Mr. Ramsay were both up next, but neither is here. Mr. Turner, do you want a question or two in their place?

**Mr. Turner:** I just had a supplementary, Mr. Chairman for clarification.



**Mr. Acting Chairman:** You go ahead with your supplementary then we'll switch to Mr. Johnston again.

**Mr. Turner:** If I may ask Mr. Bennett, for clarification purposes only. I hear the number 3.5 being used. In actual fact, is it not true that the figure for active-care beds this year, or the guideline, is actually four?

**Mr. J. E. Bennett:** My impression is that it used to be four but it's been moved down to 3.5 for southern Ontario.

**Mr. Turner:** Over a two-year period, yes, but the guideline for this year is four.

**Mr. J. E. Bennett:** For this year is four? I see.

**Mr. Turner:** And 4.5 for northern Ontario.

**Mr. J. E. Bennett:** I don't know, I am not up to date on that.

**Mr. Turner:** Thank you. Thank you, Mr. Chairman.

**Mr. J. E. Bennett:** If it were 3.5, that wouldn't change the view that I had of the 3.5 as being appropriate.

**Mr. Turner:** Right.

**Mr. J. E. Bennett:** So four is even more appropriate.

**Mr. Acting Chairman:** Mr. McClellan, I understand that you have finished. Mr. Johnston, if you are.

**Mr. McClellan:** I'll yield to Mr. Johnston.

**Mr. R. F. Johnston:** It ended up yesterday that Mr. Ramsay asked some questions that were fairly political in terms of the directions in which the three gentlemen from Wellesley thought things should go. I look at Ontario health care at the moment. I think we were right to be concerned about escalating costs in the provision of that care, but I feel that health care should take up a very substantial portion of, one, the provincial budget, and, two, our gross national product. Looking at it in those terms we should not be too concerned about knocking it down. On those two terms, do you have any feelings about the—and this is very political and you may not wish to comment—but where do you think it should stand in terms of gross national product, and in terms of the budget?

**Mr. J. E. Bennett:** My own answer would be more of a relative one than an absolute one. That is, I have no reason to change the view I had about a year ago that it probably should be about what it is now. I think it is a significant policy decision, because we are spending about what we can. Therefore the rate of increase will be tied to the economy's capability to support it. So to pick a number,

my concern as an observer of the scene, was that it would eat up an increasingly greater proportion, which bothered me a lot. It bothers people in the United States enormously; they just cannot get a grip on it. I thought that Ontario and Canada would be doing well to keep it at whatever the current proportion is by jurisdiction. You can get into a big tangle on the numbers. I haven't looked at them recently, and I forget what they are, but to set in place a number and keep it there, which is to say only grow as fast as the rate of the economy's capability to support it, seems to me a reasonable middle-ground policy position.

**Mr. Chairman:** Do you have any comments, Mr. Krasny?

**Mr. Krasny:** I guess I feel essentially the same way that Jim does, with the one modifier. I think I agree with your statement. I do believe that health and health care are absolutely top priority for any society like Ontario. I say that as a person who lives here and as a citizen. I think it now occupies a major part of the province's budget, and will almost certainly continue to do so as long as we have a public health-care system.

I also agree with Jim in the sense that the province has to try, and the country has to try, to hold the line on escalating costs. I don't have perhaps as strong a personal conviction that the current level of GNP, or gross provincial product, is necessarily the right one. If it goes from roughly seven per cent to eight per cent, or even nine or 10 per cent, over the next several years, I don't think that is an economic catastrophe. Rather though, I think the fact that it is increasing, that the underlying factors cause it to increase, often out of control, argue that committees such as this one, and ministries of health, have to become ever more astute and tough-minded in the way in which they seek to control escalating costs. Not to reduce them, but simply to control the way in which they grow.

I don't think anybody has a point of view on what an appropriate absolute amount of money is.

**Mr. R. F. Johnston:** In my view it could grow, and increase to something similar to what you are talking about. I would hope that a government in our present situation of trying to curtail costs at the acute-care institution level, would at the same time be trying to take steps to take up part of that increase in this area, and providing real community care services to compensate for the kinds of restrictions taking place. The concern I have in seeing people with the appearance of liking the guidelines as reasonable, is that I hear



the doctors coming before us from very small hospitals, doctors from Wellesley, even the OMA, talking anecdotally about problems in their own particular areas. It seems evident to me that in reality there is not the proper cushioning in providing other kinds of services in the community. I see home-care and chronic home-care programs at this stage as being grossly underfunded and in need of more assistance. I would like your comments on the alternative care side of things. Do you think they are being brought into place quickly enough to handle the kinds of changes that our acute-care hospitals are now having?

**Mr. J. E. Bennett:** I think it would be a long and slow process if we are to assume, in order to acquire those kinds of non-acute services, that it can only be done with money freed from acute services, and through implementation of bed guidelines. I think it's very difficult to get that money out again.

What we are worried about is the rate of growth, which can be quite alarming if left unchecked, rather than absolute cutbacks. Still, there is a problem. The freeing up of the money and moving around is very difficult, by definition, since the current engine assumes so much. I don't think that in the total scheme of things a great deal or adequate amount, has been done on that side.

**Mr. R. F. Johnston:** I guess I am advocating using extra money, increasing the level on the gross national product, or whatever the percentage of the budget at this stage, with other moneys while you are doing this.

**Mr. J. E. Bennett:** That is certainly a sensible alternative way to go about it. One could say that the way to get a grip on the acute system is first to stick in more on the other side, then throttle back. I haven't thought that one through behaviourally to know if you could ever then get a grip on the acute side once the other side was there—and you might end up with 12, 13, or whatever, and never have it in reasonable proportions.

[4:45]

Unlike Jack, I'd stick with the view—and it's just a notional one—that the current proportion, or something close to it within a point or so, is about right. There is a lot of money in a point of GNP.

Do you want to add anything?

**Mr. Krasny:** I guess I would say what's been said before that when you talk about whether or not it's being done quickly enough, I think somebody has to have a point of view as to what goal you're shooting for and the rate at which it's being done. I

was at a meeting discussing the chronic system in West Germany a few weeks ago. They have 13 per cent of their population of age 65 and over as compared to our number, which is more like seven or eight. They have no chronic long-term care beds. They have an average length of stay in their general hospitals of 20-odd days.

I don't know what direction they're going to go. When we started to talk about what number they ought to strive for they pointed out some quite valid things: that they lived in a fairly densely populated area; they had many more physicians and physician-like people than we have; a social system with a stronger family structure than we have; and a lower birth rate, which meant people were looking after their parents to a greater extent.

How one discounts all those things to come up with a number that says that is right, strikes me as a political decision, in the best sense of the word. It's a political decision when people simply decide how much they will delegate to that form of care and then shoot to that objective, and nobody can make that decision for the Legislature.

**Mr. R. F. Johnston:** Do you see an increased role for a paramedical kind of assistance in that area? I think of the Swiss experience, which I presume you're familiar with as well, where they have geriatric centres in Geneva and other places.

**Mr. Krasny:** I think Ontario can learn from other jurisdictions with applicable examples. In Switzerland, for every hospital they've built they have one going seven storeys underground in the event of nuclear attack. I don't think that's appropriate for Ontario. I don't think the wholesale adoption of other systems is appropriate.

**Mr. Breaugh:** They got the idea from Sudbury.

**Mr. Krasny:** They started it there.

**Mr. J. E. Bennett:** There is a word of caution, I think, and you've probably heard it before, on alternative care things. I think it is fair to say that while they have a great appeal both practically and logically and economically they can also be fouled up in implementation to the point where they become as expensive. We have done some work in St. John's, Newfoundland, with five of the institutions there, on evaluating alternative ways to do things outside the hospital setting. They had a couple of things in process which, by the time you really tagged them with all the costs they deserved, were every bit as expensive.

While supporting the general theme you are advancing on alternative ways of treatment, it's not something that can be funded indiscriminately or supported indiscriminately because there are also a lot of pitfalls and traps and hidden costs in that kind of an arrangement.

**Mr. R. F. Johnston:** It needs very long-term planning too, I would think, to implement, especially if you are trying to replace institutional care with something that is happening in the community. I think of the Lakeshore example, as a matter of fact, but I won't ask any questions about those things.

**Mr. J. E. Bennett:** We won't answer any.

**Mr. Kennedy:** I have just a couple of general questions, and we do want to thank you for coming back today and disturbing your schedule to do so.

In the work you did for Health, Education and Welfare in the United States, did you discover anything of value for us here? Could you comment briefly on that, and whether it relates? If so, how does it relate to Canada and the province?

**Mr. J. E. Bennett:** It was very interesting, as it was more the other way around. The HEW people had the impression that Canada had developed some sophisticated regulatory and planning techniques, complex and helpful ways to go about planning for a geographic area and in depth understanding of the needs of the population, and so forth. They were interested in learning these things because they thought it would perhaps help them solve a problem they have been unable to solve and that is the expenditure problem. They have just not been able, for lots and lots of reasons, to get a grip on that at all.

What we found as we compared and contrasted the two systems is that from the point of view of a sensible expenditure containment, the Canadian system has it all over the United States way of doing things by many leagues. The principal reason boils down to the fact it's a very simple system and the money is controlled at one central source in each of the provinces. There is the ability to establish and to try to get adherence to bed guidelines and to support that with the budgetary process and so forth.

What the United States has is gingerbread like you wouldn't believe—certificate of need, for example—very complex and expensive ways of regulating the infusion of capital into the system. They have planners and planning apparatuses that look at all that, and then they find at the end of the day that it doesn't have a great deal of impact. They have very complex rate-setting mechanisms—

that is, what can be charged for each day in the hospital, the services and so forth—but they have no control over volume; so the utilization of the hospital goes right up through the roof even though the rates are held down.

Leaving aside the quality of care for a moment, the real virtue of the Canadian system, from an expenditure containment point of view—you probably wouldn't believe it—is its comparative simplicity and grip on the money with a wherewithal to make political judgements on how much will be spent. All that is missing in the United States; there is no way to bring to bear a political judgement on how much will be spent. Were there the judgement, there is no mechanism in place right now, through control of the money, to be able to make it come to pass. So they all wander around and tie little bits of legislation here and there, getting more and more complex and spending more and more money, and winding themselves into real difficulties.

**Mr. Kennedy:** Is this at the national level or the state level, or is it a combination of both?

**Mr. J. E. Bennett:** Adding it all up, it's the total system level.

**Mr. Kennedy:** Did you want to add something, Mr. Krasny?

**Mr. Krasny:** I would just add that Extendicare is a company that operates about 25 facilities in Canada and 30 in the United States, and I can say—amplifying what Jim said about the quality of care—we are able in Canada to focus the energies of our people far more on the quality of care, which is what we would like to do, than we can in the United States. We are embroiled there in constant negotiation over rates, certificates of need, inspections, negotiations with all levels of government; it's a very frustrating process. While we couldn't pick out the numbers, the proportion of management and staff energy that goes simply to living with the machinery of government in the United States is, in our opinion, far too high—far greater than it is in Canada—and we are much prouder of our ability to worry about the quality of care for residents and patients in Canada than we are in the United States, just by nature of the system.

**Mr. Conway:** So much for free enterprise.

**Mr. Kennedy:** So much for free enterprise.

**Mr. Breaght:** What did you say?

**Mr. Conway:** So much for free enterprise in the health-care system.

**Mr. Kennedy:** You mentioned saying in your Financial Post series that ageing is a time bomb. What are the other highlights? Were



there other major thrusts in those articles which might be helpful to the committee?

**Mr. J. E. Bennett:** Perhaps the most general theme—and Jack had alluded to it earlier—is that it used to be understood or believed that any modern western society had an inexhaustible capability to consume resources on health care. People used to think you could always spend more; it could not be saturated.

On the other hand, continuing to spend more does not produce commensurate health benefits. There is no evidence whatsoever that additional beds, additional physicians or additional expenditures make anybody more healthy. The reason is that basic analytical work will demonstrate what a lot of people have said—including Marc Lalonde, I guess, having written it down not so very long ago—that the major causes of illness and disease are lifestyle-related, to take a complex subject and oversimplify it. What happens is that the health-care system merely picks up the pieces or tries to treat sickness rather than really focusing on health. We could spend money inexhaustibly and it would produce no greater health benefits. Those two major themes, I think, are really the starting point of all the specifics we had to say.

**Mr. Kennedy:** And the conclusions, really; those are the conclusions, in effect.

**Mr. J. E. Bennett:** That, plus a growing inability to fund the bill, come together to lead us to the conclusion that an expenditure containment strategy, or policy overall, but one which is not tightening the screws so that it starts to dig into the quality of care, is a sensible thing for the province of Ontario—in fact, for most western jurisdictions—to do these days.

We did say it took a fair amount of political courage and leadership to attempt to do that, and threw some kudos toward various politicians and ministers of health across Canada who had started to take a step in that direction. It's not a kind of political leadership you'll see much of anywhere else in the western world. You will not see it in the United States very often, although I guess Senator Kennedy would be most identified with it but perhaps for different reasons.

The UK has basically tried to take the problem out of the hides of the providers and squeezed the system to the point where the quality really is being hurt there. Canada, in our view, has the best of both worlds, that is, a high quality system and the growing conviction that expenditures need to be contained and has done something about it.

**Mr. Kennedy:** I see. The main thrust of a lot of our discussions here has been the

swinging over of active-treatment beds to chronic, and also de-emphasis on inpatient active care. Are we on the right route here? Do you see this as a legitimate course to pursue? I want to touch on the ratio a little bit later, too.

**Mr. Krasny:** I don't think anybody has more than a personal opinion on this. I don't know what are the appropriate ratios in chronic-active beds. The appropriate number, whatever it is, varies by culture and environment, the availability of physicians and the way in which they elect to practice and treat patients. Also, the desire of the patients themselves to receive certain forms of treatment, be it at home or in the hospital.

I do think, though, that the overall concept is that if you have a limited amount of resources, you have only two choices: either you decide at this level that a certain amount will go to that activity and that location and a certain amount to other things, or you bring down the available resources to the local regional level, and you ask the people whose opinion you most respect, be it the practitioners, the local citizens in the forms of district health councils or other agencies, and the physicians, to decide themselves how to prioritize the services they would provide within those resources. I think that's the right approach.

I understood, also, in the little bit of time I spent listening to submissions yesterday, they are saying themselves that they would like to have more chronic bed facilities, that they will alleviate problems in the hospitals. As long as that is being said it strikes me that that's a direction that it makes sense to go in.

**Mr. O'Neil:** Do you feel then that health councils are a good thing?

**Mr. Krasny:** I think that the process of deciding on the allocation of resources at the regional, local community level is absolutely appropriate. I think that the current district health council structure is proving to be an experiment of various levels of success, depending upon the health council, but I don't know that I really have a better alternative to offer at this time.

**Mr. Kennedy:** If this shift is acceptable, there are economies. I didn't get a chance to ask the Ontario Medical Association, but I understand, unless I interpreted it wrongly, they said something along the lines of a bed is a bed is a bed, which is true, but the whole idea is to bring about economies. The active-treatment bed is the most expensive one, so everything should be done to reduce those and go to alternatives, whether you're in hospital, out of hospital, or whatever.



**Mr. Krasny:** They were both right and somewhat incorrect. A bed truly doesn't cost any more to maintain, or costs very little more, as an active-treatment bed than a chronic, because the only factor then is the ratio of nursing to that patient day. What truly costs money, and it was highlighted in figures posed here yesterday, is the high incidence of treatment if neurosurgery goes on, if there's a hip replacement, and then in the arithmetic of hospitals, that tends to get spread over patient days, so that a patient day in the Hospital for Sick Children would appear to be extremely high; in fact that occurs because they do a great deal of surgery and very expensive intervention. If someone has a pacemaker put into them, that is spread over the patient days.

Dollars and funds can be saved if beds are converted to chronic beds if the hospital sets out to do so. If you simply convert two beds in an existing ward, then virtually nothing will be saved because the staffing remains the same. If one converts an entire ward, then more is saved because you can alter the staffing pattern. If one converts an entire hospital then still more is saved.

So, the act itself does not guarantee savings. The act is an appropriate way in which to move in the direction of savings if that particular hospital or organization wants to.

**Mr. Kennedy:** Just one other question. Maybe you'd need to declare a conflict, but the minister mentioned the analysis done by some hospitals, not by others, and I think St. Joseph's in London, which we were speaking of yesterday, is one that hadn't had this examination. What are your comments as to the savings that have been demonstrated either by your own experience or others? Could you comment on that? I think the committee could assess your response.

[5:00]

**Mr. Krasny:** I can't talk to the specific situation of St. Joe's. I believe—and it's entirely a personal impression because I've not done any in-depth study of it—that hospital administrations and boards are being as genuine and as thorough as they can be in trying to save money under the current constrained environment. In my opinion, the real opportunities lie in viewing the situation, not from the perspective of the bricks and mortar of the hospital looking out, but rather of thinking of the needs of the population in that community and how they can best be met.

In many cases that might involve cutting back on the hospital and its role and I don't think, as yet, many communities are ready to live with that notion, or understand, or

are able to manage the alternatives. That is yet to happen. I don't think it's any lack of skills or malicious intent on anybody's part; I simply think it's a learning process that this province is going through and it will simply take time.

**Mr. Kennedy:** You see a potential in this then that there can indeed be economies and still the delivery of the health care—or improvement to it for that matter? In other words, when you spend \$4 billion it seems to me that there can be some areas of economy that can be practiced without detriment to the service all of us want to provide.

**Mr. Krasny:** I don't know that for a fact. My intuition is the same as yours, and I guess from your questions yesterday most of the evidence of shortage of resources is anecdotal. I would ask you, as a committee, if you would ask these people, "Is there anecdotal evidence?" or can they be absolutely certain that all the utilization of hospitals that is currently going on is totally necessary? I don't see anybody having reason to bring anecdotal evidence to the contrary. My guess is there must be some of that as well and that the evidence goes to both sides of the argument.

I do feel that a system this large and one that has grown up as, in many ways, haphazardly as this one, has many opportunities for savings. I don't know exactly where they are. I do think that the kind of process of ratcheting down on the providers and inviting them to try to come up with innovative techniques is probably the most sensible one that can be applied.

**Mr. J. E. Bennett:** Could I just add a note there? The curious thing about a hospital—and I'll just be brief on this point—is that it's one of the few forms of enterprises with money coming in and expenditures made where nobody really has a grip on the total economics of the place. The hospital administrators, for all practical purposes, together with their boards, control only a very small portion of hospital costs; namely, the pure administrative functions and the hotel and support activities.

The bulk of the costs are determined by decisions taken by individual practising physicians, and seldom do you hear either individual physicians or spokesmen for the physicians saying, "Really, the driving force behind hospital costs is patterns of utilization, tests that are ordered, lengths of stay, numbers of admissions, the way we choose to treat our patients," and so forth.

To take a very rough number, 67 or 70 per cent of hospital costs are in the long term

determined by the decisions physicians take and as they are individual practicing professionals it is very difficult to get a grip on those decisions and move them in any kind of more cost-effective direction. The poor hospital administrator is sitting there with the pressures of a lower budget, a board that is anxious that he balance that budget, and no control over the individuals who in fact caused the costs. I should add the patients—

**Mr. McClellan:** Is it impossible to get a handle on that? Are you saying that it's impossible to get a handle on that?

**Mr. J. E. Bennett:** No, I'm saying it's very difficult. It is not possible for a hospital administrator.

**Mr. McClellan:** I understand that.

**Mr. J. E. Bennett:** In those institutions where there has been a real impact on utilization—and I doubt if there are all that many—it's because the physicians have been involved in a co-operative effort, almost a self-disciplining one, and said: "What can we do to be more timely in our management of the course of care? What kind of discharge policies, as a group practicing in this hospital, should we follow? Let's get behind day surgery," and things of that sort.

That's what really cuts down utilization, and absent that, the ability to muster physician support in one way or another, the poor hospital administrator has only the 10 or 15 per cent of costs that he can control; and he squeezed them. Coming back to Jack's point, a number of administrators throughout the province have done a lot, quite conscientiously and in many cases successfully, to squeeze out a couple of percentage points, or four or five, from administrative costs. But the driving force remains under physician control.

**Mr. McClellan:** I would suggest, around the use of the term "political courage," that the test of political courage would be to confront that area.

**Mr. Chairman:** Thanks, Mr. Kennedy, and thank you, Mr. Bennett and Mr. Krasny. We appreciate your time.

**Mr. J. E. Bennett:** We enjoyed the opportunity to put forward our views.

**Mr. Chairman:** Thank you again.

**Mr. McClellan:** I want to say also how much we enjoyed your report on the Lakeshore Psychiatric Hospital.

**Mr. Chairman:** We will move on. The committee members have been circulated with a report to the standing committee on the transfer of inpatients from Lakeshore to Queen Street. We agreed that this would be

discussed now, and I would be pleased to do that. Mr. Conway?

**Mr. Conway:** Mr. Chairman, we as a caucus discussed the matter this morning, appreciating the material which we were supplied. I presume all members have the document. It was our desire—and I would move, I suppose—that the committee set aside next Monday to invite the inpatient transfer committee mentioned in the first page, in the introduction of the report we are now looking at, to appear before the committee so that my colleagues, who had expressed the desire, could engage in some cross-examination on the basis of the report. It's the desire of my colleagues, since for them the re-referral was predicated on an ability to cross-examine the principles of the transfer committee, that it take place at an early opportunity, and we would like to do so next Monday, recognizing that the time is obviously coming quickly to a critical point.

To reiterate and conclude, it's the desire of my colleagues that we set aside next Monday to invite the inpatient transfer committee, which is referred to in the first paragraph of this document, to appear before the committee for purposes of such discussion as members may find useful and necessary. If that's needed in the form of a motion, I can so move.

**Mr. Chairman:** Excuse me, you've moved that as a motion?

**Mr. Conway:** I would move that as a motion, if it's required.

**Mr. Chairman:** Can you file it with the chair? Mr. Lawlor?

**Mr. Lawlor:** I'm hesitant about that particular move simply because of the time limitations facing us with respect to the House itself and the work done there.

I would dearly love to interrogate on the basis of this thoroughly inadequate statement. In the last few days a number of things have happened. For instance, the child unit at Queen Street is being transferred to Whitby, which is a new move, et cetera, in order precisely to provide the space. We had been informed previously that the space was at our disposal, but obviously it's not. The SOC unit, the orientation unit, at Lakeshore is also said now to be transferred to Whitby. The role of the occupational therapy unit has become highly dubious at this stage; I thought that was nailed down.

None of this is contained in this statement that has been presented today. These are major and critical changes in ministry plans as we go along. Why they don't come clean and give to this committee a full statement



of exactly what they intend—which is what we asked for and what they know is coming up this afternoon—quite puzzles me. Is there an attitude of recalcitrance and possibly even contempt with respect to the work of the committee?

I'm told that the detox unit is being moved out, almost for certain. The dialysis unit, which I thought was more likely to stay at Lakeshore on the basis of ministerial statements, is in the air. It seems to be indeterminate. All these things cause me some alarm. I think I'm not being kept clued in and informed, which is the very work of this committee. I would love to interrogate these things and to find out what really is happening there.

At the same time, to bring it over to Monday leaves absolutely no time to debate this matter in the House or to bring it back at least with a recommendation to the House and to canvas it. We can bring it back to the House but there will be no opportunity, so far as I can see, for the House to give any consideration whatsoever to what we say one way or the other. For that reason, after this matter is over, I prefer to move my own motion, which I shall circulate shortly, and which places the whole situation under suspension for a limited period of time. I would ask that you receive the subsequent motion.

**Mr. Kennedy:** To speak first to Mr. Lawlor's point, the motion to refer back was to deal with the inpatients. Mr. Lawlor was speaking of the outpatient services. What it went back for was to get a timetable of the movement, which has been provided. I was going to ask Mr. Conway what we would be asking the inpatient committee. I see the schedule here as to what is proposed. It's set out there in accordance with his motion, which was approved by the committee, asking for this very material.

**Mr. Conway:** I can tell you, Mr. Kennedy, that our caucus reviewed the material today. They instructed me very clearly that while they had voted for the re-referral they had done so on the expectation of—and I can be quite candid with you here—a much more complete report than they had received or that they have now before them. They felt it very important that the opportunity be provided at an early juncture to cross-examine the inpatient transfer committee, made up of the principals from both facilities, and to examine the detail, such as it is, outlined in this particular report.

As for the sort of matters our people wanted to pursue, for example, I draw your attention to the minister's letter to the member for Lakeshore which is appended to the

statement. The bottom paragraph reads: "I have, therefore, asked my staff, including the administrators and medical directors of both institutions, in consideration of the best interests of patients and staff, to advise on the following questions: the most appropriate arrangements and timing for the completion of the moves of inpatients..." That's dealt with to some degree in the previous four pages.

On the second point, the change in admitting practices resulting from the rearrangement of catchment areas for the Queen Street Mental Health Centre, some of my colleagues felt that that was inadequately dealt with in the preceding four pages. In his letter to Mr. Lawlor, dated May 31, the minister indicated there was going to be some effort to deal with that. My colleagues just felt it wasn't adequately dealt with in the three and a half pages. That's the sort of procedure that they felt the cross-examination on Monday would provide. I can only communicate their desire, and that's is.

**Mr. Kennedy:** It's certainly an interesting thing to know about the admitting practices and, in fact, the matter came up in many of the discussions. But, as such, it wouldn't have anything to do with the movement of the particular patients in question because this would be an operational move, as indicated here. The Liberal Party supported the discontinuance of the inpatient service and the movement of patients basically. I don't feel competent or qualified to question medical staff on precisely how these movements take place. I have confidence in them, as I've said before, but it bothers me with respect to the overall welfare of the patients. I think that's the overriding issue and as such I don't feel able to support your motion, Mr. Conway.

[5:15]

**Mr. Conway:** I accept your point, Mr. Kennedy. We maintain our commitment to inpatient transfer, but we feel very strongly that it must be done in the context of a substantial amount of planning to provide for the smoothest possible transfer. My colleagues, as I think you have properly characterized, are continuing to support that in principle, but only when there is a good outline, such as I've just described in regard to the minister's letter, and when other things as they relate to general hospitals within that whole question are dealt with. I would be unfair if I did not express on behalf of my colleagues their dissatisfaction with the three and a half pages. They had anticipated a more extensive planning document and they instructed me to put that as



part of our commentary, and I do so without wanting to take any more of anybody's time.

**Mr. Chairman:** Mr. Sweeney and then Mr. Lawlor.

**Mr. Sweeney:** Mr. Chairman, clearly our concern is that the plan we had asked for would have to be presented prior to any support whatsoever for transfer of inpatients, which is not sufficient in what we've already been given.

I would draw the chairman's attention to the letter that was mailed to you, sir, on May 10 by Dr. Guirguis in which he had indicated that the lack of adequate planning was resulting in a number of serious problems at Queen Street with respect to these patients. I would like to draw your attention to three or four of the points they raised which, quite frankly, Mr. Chairman, have not been addressed in the plan that has been given to us so far. For example, on the first page, paragraph (a) at the bottom, he refers to people being moved in before facilities were adequately prepared, which resulted in overcrowding. We don't know, despite what this particular document says, whether or not the plan that is now being proposed will not result in exactly the same thing. We just don't know that.

On the next page we see that this has resulted in premature discharge of some other patients. Will that continue to happen with this plan? We don't know. The reference here is to the fact that open wards are now being locked. Will this plan continue that practice? We don't know.

It goes on and says that there's a higher incidence of injury to staff and patients. Is that going to be resolved? We don't know.

It goes on to point out that they're concerned about the maintenance of academic standards since it is a teaching hospital. Will those academic standards continue to deteriorate or continue to be put in jeopardy by this plan? We don't know.

The letter goes on to say that this has created more uncertainty and confusion about existing and future community-based services. That has not been resolved. On page three it's drawn to our attention that this will lead to community demands for more acute services to be transferred from Queen Street to other hospitals in the area. Will that practice continue, and to what detriment of those other hospitals and the patients? This plan doesn't answer that question.

Finally the letter goes on to point out we need a periodic review of the complement and budget necessary to ensure high standards of care for patients. Now it is true there is a reference here to a staffing com-

plement, but is it sufficient to meet the needs? Mr. Chairman, what I'm trying to say is that this report in no way meets what we had asked for. There are still far too many unanswered questions. Granted, it's better than nothing, which we had before. Quite frankly we have to ask ourselves parenthetically when this report was even made up. The date on it says June 7, 1979. Surely there had to be something before that. That's one major issue.

The second major issue, and why we are requesting the appearance before us of the inpatient transfer committee, is simply to raise these questions with them to see whether or not this plan does in fact respond to those concerns. The second point, which Mr. Lawlor pointed out, is that it is true that we did not specifically ask for an outpatient guideline with respect to Lakeshore, but the point that came up time and time again is that the inpatient operation and the outpatient operation are not completely separate compartments. There are certain overlapping factors.

Although we did not ask for a complete plan as to what was going to happen or continue to happen with respect to the outpatient practices at Lakeshore, we do recognize that the transfer of almost 80 staff from Lakeshore to Queen Street may very well have an impact on the outpatient program at Lakeshore. We don't know that, so we felt that at the very least the overlapping complement, the overlapping programming at Lakeshore would have to at least be referred to in this document and it wasn't. We don't expect a complete document with respect to the outpatients, but we do expect that they would at least appreciate that we recognize that there is that overlapping factor.

What we're clearly saying is, yes, the Liberal caucus did say if there were an adequate plan placed before us—

**Mr. Kennedy:** No, I didn't say that.

**Mr. Sweeney:** If a plan were placed before us, and surely it had to be understood that the plan had to be a satisfactory one, that it would answer questions that have already been raised, not by us I should say, Mr. Chairman, but by the people who are actually in Queen Street right now. This plan does not do that.

Therefore I would ask for the support of my colleague's motion. The very least we have to do before we can go any further is either have the minister give us a more complete plan, or bring the inpatient transfer committee before us at the earliest possible date. Monday is listed because that is the

earliest possible date that this committee will meet. We need to ask them to verify whether or not the concerns described can be met by this plan. Otherwise, there is no way we can support it. We have been put into an extremely awkward situation and I want to say, Mr. Chairman, through you to the minister—and I hope you pass this on to him—that quite frankly we resent being put into this position.

**Mr. Kennedy:** Don't get carried away now. We can always shift to the Liberals, and you know it.

**Mr. Sweeney:** I think we have gone a long way to show our willingness to understand and to co-operate, and I think that is on the record. We have not deliberately put obstacles in the way of this transfer. If it could be demonstrated to us that it is in the best interests of the patients, both the inpatients moving to Queen Street and the outpatients remaining at Lakeshore, and that it would be done in a responsible way—I think what we're asking for is reasonable and responsible and that it is the very least we can ask for, if the ministry continues to wish our support.

**Mr. Chairman:** Mr. Lawlor, then Mr. Turner and Mr. Jones.

**Mr. Lawlor:** The reference back here is somewhat broader than has been indicated, if I may say so, by Mr. Kennedy. Sure the debate devolved around the inpatient situation and the merits of the planning of that particular movement, but that's not what the motion says. The motion I moved, which was accorded to, was that the motion of the adoption of the report of the standing development committee dated May 25 regarding Lakeshore Psychiatric Hospital be amended by striking out the words "be adopted" and substituting therefor the following words "it be recommitted to the said committee for reconsideration," which doesn't delimit it, as I see it, in any particular way. Although our primary concern at the moment is with respect to the inpatient situation, as Mr. Sweeney has pointed out, it is necessarily, intrinsically, tied in with the outpatients.

What we all want is a plan that will indicate that a wide range of services is available, that it won't be disruptive, and that outpatients as well as inpatients are receiving a proper adoption accommodation. The plan before us at the moment doesn't indicate what disposition has been made in any definite way with respect to the outpatient situation.

As far as the inpatients are concerned, it is thoroughly inadequate. They mention buses, for heaven's sake, and that is as far as they go. That can hardly be considered adequate to the intent of the debate in the House.

**Mr. Turner:** With great respect, Mr. Chairman, I am disappointed and more than a little concerned over the welfare of the patients involved. We seem to be talking about everything else except the people to whom we owe the greatest responsibility, and that is the patients.

Another thing that concerns me, Mr. Chairman, is that this committee, and it may be following a pattern which concerns me greatly—

**Mr. Lawlor:** We are concerned about overcrowding at Queen Street too, you know, and the condition of the patients—

**Mr. Turner:** I didn't interrupt you, Mr. Lawlor. I would ask you not to interrupt me, thank you.

**Mr. Lawlor:** Well, I am interrupting you.

**Mr. Turner:** Another thing that concerns me is the whole committee structure, not only this committee but other committees, but this committee as it pertains to this particular issue. I have to ask myself whether the committees are indeed usurping or replacing the responsibility of government to make decisions.

**Mr. Sweeney:** No, not at all.

**Mr. Turner:** Quite clearly that is what is coming through to me, and that is not the purpose of the committee.

Interjections.

**Mr. Chairman:** Mr. Turner has the floor.

**Mr. Turner:** I respectfully point out to you, sir, the minister is very much concerned. I refer to the letter which was referred to by the member for Lakeshore earlier, in which the minister does display his concern. If I may quote from it:

"The patient move from Lakeshore to Queen Street which was planned for May 30 was delayed as requested, as a courtesy to the standing committee until its report could be brought to the Legislature. However, I must add that the delay was a matter of grave concern to the professional and administrative staff charged with the heavy responsibility for these programs.

"When a major health-care facility is being phased down, I know you will understand that with the attendant transfers and loss of staff as well as the administrative difficulties involving patients, staff, relatives, outside



social agencies, et cetera, there is a point where the declining support services and staff morale become an important factor that can jeopardize the quality of patient care and the continuing integrity of the program."

The minister, quite clearly, has been advised by his professional and administrative staff that this point has now been reached. My concern has to be on behalf of the patients. The minister has been told by his professional staff that the point of danger has been reached with regard to the transfer of these patients, and I would respectfully submit that we just can't afford the luxury of waiting.

With all respect to the committee, I am not trying to short-circuit any process, but if we in truth are concerned about the welfare of the patients we must not delay this program any longer. Thank you very much.

**Mr. Jones:** In the light of Mr. Turner's comments, Mr. Chairman, I will be brief. I just want to associate myself with the comments of my colleagues, Mr. Kennedy and Mr. Turner. Clearly we are seeing inconsistency, with all due respect to our Liberal members of the committee. The report clearly said such a plan has been submitted by the minister to the social development committee and we have that.

[5:30]

The concern we have all expressed for the kind of care of the patient being the priority, and those people who have that difficult, delicate, sensitive job. It concerns me a great deal that they are being hamstrung by being hauled before the committee. I use that term advisedly. I know they would be received well, but there they are in the midst of something as sensitive as this and we are hauling them in yet again to put them through almost an inquisition. We are calling the report into question before they even arrive, starting to talk about what kinds of buses and just attach the suspicion they won't use the kind of sensitivities those people in those positions of responsibility would do as an instinct of their profession.

That concerns me a great deal; so I associate myself with the comments of my colleagues Mr. Kennedy and Mr. Turner.

**Mr. Blundy:** Mr. Chairman, I would like to make a couple of comments on what has been said. I support the motion of Mr. Conway.

In this committee over a period of time we have heard some of these people who are actually members of the inpatient transfer committee, which has now been referred to, who did express opinions and even expressed

some doubts about the taking of the patients all at once to Queen Street, about the capacity of the hospital to handle them, about the effects on the community-based services, outpatient services in the community and so forth.

There was also some fairly lengthy discussion about the problems of referrals from other general hospitals in the catchment area of Lakeshore which were not really resolved. I think we are protecting the people who are the patients in Lakeshore hospital by wanting to make sure these things are studied and that they are prepared for them.

As for Mr. Turner's mention of our jeopardizing the quality of patient care and so forth, I think that was started with a bang on January 22, when the minister announced the closing of the hospital.

All we are saying is that we should wait until Monday and ask these people if all the concerns that they themselves expressed in the hearing have been met, they are not worried about the transfer any more and if it will be done with no problems to the patients concerned. Then, as far as we are concerned, it can be closed; so the delay is minimal.

All we are asking is that we be reassured by these people who make up the inpatient transfer committee and who previously did express some concerns about the situation. If they allay those fears, then there is no further delay.

**Mr. Chairman:** I think we have had a very good go-around. Mr. Sweeney has indicated he wants to speak; so does Mr. R. F. Johnston and now Mr. Conway.

I should tell the committee I have a bit of a time problem; I really should leave about 5:50. I would hope we could wind this up.

**Mr. Conway:** I just would like to say a concluding word. I know members want to have the question put. I want to deal with one or two of the points that were made. We are sensitive to the fact the transfer date is coming up; June 20 is next Wednesday. It was our desire the committee would deal with this matter on Monday to ascertain what it was the inpatient transfer committee felt was the current state of capacity and related questions.

It might be perhaps unfair to suggest it—I forgot to bring the article with me—but you may have noticed in yesterday's Toronto Sun, which one of my colleagues from Toronto brought to my attention, an article reporting that a Queen Street patient was associated with a death over the weekend. One of my colleagues raised a question which reminded me almost of the minister's initial



statements about Lakeshore last November, that we had a facility with which deaths were associated in that case of fire. My colleague from St. George referred me to the article in the June 11 Toronto Sun, which states that the driver of a stolen car involved in the killing, to quote the article, "had walked out of the Queen Street Mental Hospital Centre."

I don't know whether that article is in any way factual or whether that represents the case there, but one of my colleagues brought this to my attention in connection with her desire to have this committee here Monday to discuss that kind of question.

That is the rationale for our position in that connection, to say nothing of the desire of the caucus to pursue with some degree of consistency the investigative nature of this inquiry. I will stand my case on that, and I just draw the honourable members' attention to that particular article.

**Mr. R. F. Johnston:** Could you just read me the motion?

**Mr. Chairman:** "Mr. Conway moves that the inpatient transfer committee referred to in the MOH statement be invited to the social development committee on Monday, June 18, for such discussion relating to the planned transfer as members deem useful."

**Mr. R. F. Johnston:** I would speak in support of that, just for a second. I think any further discussion that might get the Liberals to change their position and come and support our position in the long run would be a wonderful thing. I think we should have the vote.

Motion agreed to.

**Mr. Lawlor:** Mr. Chairman, as far as my motion is concerned, I shall put it over until Monday.

**Mr. Chairman:** All right: We will make the appropriate arrangements to have the inpatient committee come before the committee on Monday. We will be meeting tomorrow all over the province and, thereafter, Monday next to hear the inpatient committee.

The committee adjourned at 5:37 p.m.

## SPEAKERS IN THIS ISSUE

---

Blundy, P. (Sarnia L)  
Breaugh, M. (Oshawa NDP)  
Conway, S. (Renfrew North L)  
Gaunt, M.; Chairman (Huron-Bruce L)  
Johnston, R. F. (Scarborough West NDP)  
Jones, T. (Mississauga North PC)  
Kennedy, R. D. (Mississauga South PC)  
Lawlor, P. D. (Lakeshore NDP)  
McClellan, R. (Bellwoods NDP)  
O'Neil, H. (Quinte L)  
Sweeney, J.; Acting Chairman (Kitchener-Wilmot L)  
Turner, J. (Peterborough PC)  
Warner, D. (Scarborough-Ellesmere NDP)

**From McKinsey and Company:**

Bennett, J. E., Consultant

**From Extendicare Limited:**

Krasny, J., Vice-president



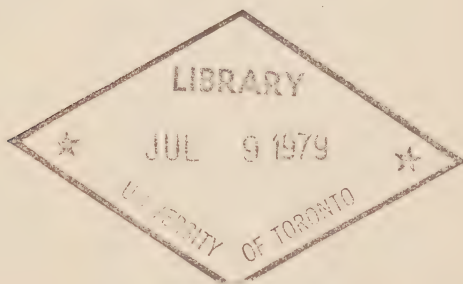
No. S-26

# Legislature of Ontario Debates

## Official Report (Hansard) Daily Edition

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



### **Third Session, 31st Parliament**

Monday, June 18, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

MONDAY, JUNE 18, 1979

The committee met at 3:50 p.m. in committee room No. 2.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

(continued)

**Mr. Chairman:** I call the committee to order. We have a quorum. Today we have the Hospital Transfer Committee, but before we get into that, the minister wishes to make a statement.

**Mr. McClellan:** Do you have a copy there?

**Hon. Mr. Timbrell:** No. I'll read slowly so you can take notes.

As the members are aware, the scheduled transfer of inpatients from Lakeshore Psychiatric Hospital to Queen Street Mental Health Centre was delayed some three weeks ago as a courtesy to the standing committee. Members will recall that subsequently I sent a letter to the member for Lakeshore, expressing the concerns of the professional and administrative staff, who have direct responsibility for the patient transfer. I would like to read that letter into the record. It's a letter dated May 31, addressed to the member for Lakeshore (Mr. Lawlor).

"Dear Patrick:

"This is further to your letter of May 25, 1979, and our subsequent conversation.

"The patient move from Lakeshore to Queen Street, which was planned for May 30, was delayed as requested as a courtesy to the standing committee, until its report could be brought to the Legislature. However, I must add that the delay was a matter of grave concern to the professional and administrative staff who are charged with the heavy responsibility for these programs.

"When a major health-care facility is being phased down, I know you will understand that with the attendant transfers and loss of staff, as well as the administrative difficulties involving patients, staff, relatives, outside social agencies, et cetera, there is a point where the declining support services and staff morale become an important factor that can jeopardize the quality of patient care and the continuing integrity of the programs. I am advised by my professional and admin-

istrative staff that this point has now been reached.

"I have therefore asked my staff, including the administrators and medical directors of both institutions, in consideration of the best interests of patients and staff, to advise on the following questions: the most appropriate arrangements and timing for the completion of the moves of inpatients; the change in admitting practices resulting from the re-arrangement of catchment areas for the Queen Street Mental Health Centre.

"As I indicated in our conversation, I have no choice but to be guided by this advice.

"I would like to inform you at this time that, because of staff scheduling and other pertinent considerations, the appropriate dates will be June 20 to terminate admissions at Lakeshore and proceed with the move which was postponed from yesterday, and August 1 for the remainder, namely units A and B. I am advised that smaller-scale interim moves are not appropriate.

"Under the circumstances I have no choice but to instruct my staff to proceed with planning and implementing these moves on these dates. I am advised by my staff that having undertaken this course of action in the best interests of patient care, it will not be administratively possible or professionally acceptable to have any further delays."

Following last week's request from this committee to hear from the inpatient transfer committee, my deputy minister again asked the senior staff directly involved with the move for their best advice. This reaffirms the content of my May 31 letter to Mr. Lawlor. I would now like to read this advice, dated June 13, into the record.

**Mr. Lawlor:** Before you do, I am advised that there is no morale problem, that it's—

**Hon. Mr. Timbrell:** Perhaps I can read the letters and finish my statement, then we can discuss it, Mr. Chairman. The first letter, addressed to my deputy minister, is from Dr. I. K. Bond, the medical director of Lakeshore Psychiatric Hospital.

**Mr. Lawlor:** What's the date?

**Hon. Mr. Timbrell:** June 13. They are all dated June 13.

**Mr. Lawlor:** Two weeks afterwards.

**Hon. Mr. Timbrell:** Mr. Chairman, as I have indicated, this reconfirmation of advice was asked for following the committee's decision last week not to finalize its deliberation on Lakeshore and report back to the House, but rather to ask for the inpatient transfer committee to be here today. I wanted to check that advice again through the deputy, and these are the letters. The first is from Dr. Bond:

"I have been asked by the director of psychiatric hospitals to comment on and confirm the content of Mr. Timbrell's letter to Mr. Patrick Lawlor, MPP.

"I would like to state at the outset that as a civil servant I have not been involved in any way with the political decision to close Lakeshore Psychiatric Hospital, and I would deeply resent being involved in any political manoeuvres at this stage of the procedure. I still hold my private view that the closing of Lakeshore Psychiatric Hospital was unfortunate and misguided. Having said that, I must address myself to the present situation here at Lakeshore.

"The prolonged uncertainties and changes of plans have undoubtedly brought the morale of the staff of this hospital to a deplorable state. With regard to the actual treatment of patients, there is no problem with the clinical staff, i.e., nursing and medical, who will continue to give adequate care to their patients under any circumstances. However, the hospital cannot operate without support staff, and these support staff are continually being eroded to a point where it will not be possible to continue to operate this hospital much longer.

"Therefore I would have to agree that any further changes in plans or uncertainties cannot help but be detrimental to everyone including staff, patients and relatives."

The second letter is from the acting administrator of Lakeshore Psychiatric Hospital, Mr. McMullen, addressed again to Mr. Campbell, my deputy minister.

"Rumours abound that there may be a further deferment in the closure of wards three and four on June 20 and A and B on August 1, 1979. I would like to advise you that in my opinion such a deferment would impinge on the quality of nursing care and would indeed be unfair to both patients and staff.

"The morale of the staff at Lakeshore has now reached such a level that I have serious concerns regarding the provision of services to support health care."

The third letter is from Dr. Durost, the medical director of Queen Street Mental Health Centre.

"I have been asked to comment on the difficulties created by any further delay in the orderly transfer of inpatients and staff from Lakeshore Psychiatric Hospital to Queen Street Mental Health Centre.

"From my viewpoint, as a clinical administrator, I am deeply concerned by the impact of the uncertainty created by the present situation. Staff and patients of units three and four were fully prepared for transfer to Queen Street Mental Health Centre on May 30, only to be told 24 hours before the move that it was to be postponed. For 50-plus patients, and nearly as many clinical staff, this could only have been a very disturbing experience, particularly for the patients, many of whom had been only recently admitted to the Lakeshore Psychiatric Hospital and who therefore would have been in an acute phase of their illness.

"Further delays will, besides undermining the ability of staff to provide an acceptable level of patient care, be confusing and disconcerting to relatives and to the community agencies which currently relate to the Lakeshore Psychiatric Hospital. This is obviously undesirable, and the necessary step to be taken to normalize the situation should, in my opinion, be taken immediately.

"I would add that I fully support the points made by the Honourable Mr. Timbrell in his letter of May 31, 1979, to Mr. P. Lawlor, MPP for Lakeshore."

The final memorandum is from Mr. Fisher, the administrator of the Queen Street Mental Health Centre.

"In my view, further delay in the plan for closure of Lakeshore Psychiatric Hospital would have an adverse effect on both patients and staff.

"We must not ignore that the patients to be transferred to Queen Street Mental Health Centre are seriously mentally ill. Many are anxious or upset, depressed, paranoid and delusional. Some are actively hallucinating and could be suicidal. The prospect of being moved to a new facility must be a cause of considerable added stress.

"The patients have been again prepared by Lakeshore Psychiatric Hospital's wards three and four staff for the move on June 20. We will be showing an orientation slide show on Queen Street Mental Health Centre to the patients on wards three and four at 15:00 hours today and tomorrow." That was last Wednesday and Thursday.

"Staff at Lakeshore Psychiatric Hospital and Queen Street Mental Health Centre have again been prepared for the move of acutely ill patients and the assumption of Lakeshore



Psychiatric Hospital's admissions. Another delay would be very difficult for both staffs to understand and accept. We owe the staff and patients sufficient respect not to expose them to the further anxiety of a delay and what must be perceived as indecision."

Mr. Chairman, I appreciate the responsibility of this committee to review major policy decisions such as the closure of Lakeshore. I understand the majority of this committee is in agreement, or has been in agreement, with the decision to close Lakeshore as an inpatient psychiatric facility. However, I point out to the committee that the responsibility for the ongoing care of the mentally ill patients at the Lakeshore facility rests with the Ministry of Health and its professional and administrative staff. As minister, I must be guided by their advice.

The four letters I have read into the record leave no doubt in my mind that the patient transfer must continue on schedule; this course of action is clearly in the best interests of both staff and patients.

Mr. Conway: Before Mr. Lawlor speaks, I wonder if I might raise a point of privilege. The question was raised, I believe, by the leader of the New Democratic Party (Mr. Cassidy). I wanted to begin by giving the minister an opportunity to explain clearly to this committee what I think is a procedural difficulty that I was not happy about. I'd like him to recount some of what he indicated in the House the other day, because quite frankly I lost him early on. It has to do with the fact that some time ago this committee expressed a desire to have a report to the committee outlining the nature of the inpatient transfer. That was provided on a subsequent day.

Hon. Mr. Timbrell: That was Friday, whatever it was, June 8.

[4:00]

Mr. Conway: That's right. Certainly it was thought to be sparse and in some cases not very adequate, but none the less it did meet the requirements of at least something. I was personally distressed to hear from the leader of the New Democratic Party that there did exist a much more comprehensive statement available for somebody. I never did find out for whom, whether it was sent by your ministry, or who in the ministry was responsible for it. I read it over the weekend. I noticed a correlation in some areas, some very specific pages, et cetera, or parts of pages.

I think it's not unreasonable for people to think that there was a difference of opinion, perhaps, between the kind of report that we

had expected, on the one hand, and on the other hand, a sense almost of being held in some contempt by knowing that other people on the spot were in receipt of a much more extensive statement of the inpatient transfer. I wonder if the minister could clear the air. I don't want to take too much time in this connection.

Hon. Mr. Timbrell: Mr. Chairman and Mr. Conway, the leader of the third party never sent me a copy of what he was brandishing about that day, so we're just looking at your copy—

Mr. Conway: That was part of it.

Hon. Mr. Timbrell: —but I'm sure there have been many memoranda back and forth for the last five months.

Mr. Conway: That was a 21-page document that looked a lot more in-depth and extensive than the three-page or 4½-page document that we received and I just wondered why we did not receive that.

Hon. Mr. Timbrell: As I said the other day, the committee was not altogether clear as to what it wanted, so we were somewhat in the dark. We gave you the material on the Friday, hoping you would have time enough on the weekend to review it and indicate to us on Monday what further information you required. I believe you and the chairman of the committee were called, and correct me if I'm wrong, to see if there were any specific questions. My understanding was that it was reported that there would be some questions at the committee.

In fact, I was set to go that day to the Salvation Army Grace Hospital, the commission of the converted hospital for chronic care, and then to London. I believe my staff representative offered, if it was felt necessary by the committee, to cancel out of these things. I'm told that he was told, no, that wasn't necessary, as long as people were here to answer questions. Staff were here to answer questions. To the best of my knowledge, their presence was made known to somebody, but they weren't called.

Mr. Conway: With all due respect, Mr. Minister—and I can appreciate that, I just want to give you an opportunity to respond and I want to make one thing very clear. It would distress me very much to think that the committee had asked for a document which was available in a much more extensive form than the précis which was first presented to it. It came from the leader of the New Democratic Party—

Hon. Mr. Timbrell: I'm not sure, either.

**Mr. Conway:**—and I appreciate your comment on it. I just wanted to state my personal concern that we may not have been given all the data immediately at hand. Indeed, you make a point about calling on myself and the chairman of the committee. I think I was away at a place called Rolphoton, on the date of that call. I wasn't expecting a great deal because, quite frankly, I didn't think there was very much by way of a written report concerning these transfers. It bothered me very much to hear last Friday that there was some kind of a document, which appeared to be very much related to what we had asked for and that this was brought to the attention of the House by the leader of the NDP.

**Hon. Mr. Timbrell:** As I said, I'm sure, Mr. Chairman, and to you, Mr. Conway, that there has been a great deal of communication back and forth at various levels within the ministry and the various mental health centres involved. Certainly, the purpose of the three-page memo was to give you all of the salient information and, obviously, answer any other questions you have. There have been a great many issues discussed with the committee, so certainly—

**Mr. Conway:** At some point today, I'd like you—and perhaps you might confer with the members of the New Democratic Party—to tell me what exactly that document represents.

**Hon. Mr. Timbrell:** I'm not sure what it is, but okay.

**Mr. McClellan:** Maybe I can help, Sean.

**Mr. Chairman:** On the point of privilege, Mr. McClellan?

**Mr. McClellan:** Yes, Mr. Chairman. The document is entitled, Proposed Patient Services for the Lakeshore Psychiatric Hospital Catchment Area. It's a 21-page document with an additional page attached; the heading on this 22nd page is "Implementation Plan, New Expanded Outpatient Programs, Lakeshore Catchment Area." It's dated May 29, 1979, and it sets out a timetable for a set of decisions that have to be taken.

The concern I have is that the three-page report which was entitled, Report to the Standing Committee on Social Development on the Transfer of Inpatients from Lakeshore to Queen Street, which was dated June 7, is taken from this report because there are sections that are verbatim in both reports. However, the report we received is, if I can use the adjective, an expurgated report. It doesn't deal with some of the problems identified in the 22-page document. I think it is very regrettable that problems with respect

to a number of items identified in the larger document, which I hope we get some answers on today, were not indicated in the short report given to us.

We were given information that was incomplete and partial. It left us with the impression that everything was copacetic; everything was proceeding apace; there were no problems. But in fact some problems were identified which the minister and the ministry's staff should have known would have been of interest and concern to this committee. I put it to you, Mr. Chairman, that the material should have been made available to us and should now be made available to the other members of the committee. It was serendipitous that we were able to obtain a copy of it.

**Mr. Chairman:** Mr. Minister and then Mr. Kennedy.

**Hon. Mr. Timbrell:** I was just going to say, Mr. Chairman, I would not have offered to be here myself last week; I would not have made sure the staff were here; I would not be here myself today if I weren't anticipating that you would have questions beyond the three-page memorandum which was sent to you. We had, with respect, no indication last Monday from you that you required additional information. Certainly, there was no intention to mislead or otherwise withhold information from the committee. I've only got to page seven so far, but I haven't come across anything yet that hasn't been the subject of discussion several times when staff were here earlier on in the deliberation of the committee—and for that matter myself.

**Mr. Conway:** What is it, who wrote it, to whom was it sent and when was it sent? That's all I want to know.

**Hon. Mr. Timbrell:** Yes, well, I'll find out.

**Mr. Kennedy:** Mr. Chairman, in all fairness, as an unbiased member who didn't know—

**Mr. Breagha:** What?

Interjections.

**Mr. Kennedy:**—the background of this request and apparently things other members on this committee knew, the report came back here and when it came back, being sponsored in its return by the NDP, then it seemed that the Liberal Party would be happy presumably if they had this first part of their position on the transfer acceded to. This was that the move take place, provided that the transfer can be accomplished in an orderly, well-planned fashion and that no transfers take place until such a plan has been submitted by the minister to the social development committee. That was the operative section that brought forth this report.



I received this, as did other members, and to me it had the salient points, "on such-and-such a date so many patients will be moved," and that's the way it would be. To me it seemed to answer the basic request contained in this. The committee report didn't ask for details such as you've now put forward and which you say are available within the files, presumably—I guess they were in the file; I don't know if there are brown envelopes going around or not. But to me this answered the salient points on the request and it seems reasonable to me that we take this and then ask detailed questions.

If the fact that it's only a three-page report upsets people, it certainly didn't come through to me, other than saying basically what is to transpire. To say that a whole lot of other background material should have been provided, I'd have to say, Mr. Chairman, the request contained in this report has been answered. I think it would be a judgement call as to how much the committee wants to know. I don't think it's quite fair to attack the minister, and presumably staff, because the response to the request isn't a little more full.

Mr. Conway: I don't want to take too much time on that point of privilege. It does distress me, as I said earlier, that this information did come forward, and I would be upset if I thought there was a parallel document, lengthier and more expressive of the intentions of the ministry, that was not provided. I don't think that is an unreasonable position and I recognize that we have invited guests today and I don't want to prolong this to too great a degree, but at some point today I would, as one member, like to know what that document was, who wrote it and—

Hon. Mr. Timbrell: I'm told it was a working paper, distributed among senior management and used in discussions at Lakeshore and Queen Street. And that's the best way to describe it, a working paper.

Mr. Lawlor: Was it available on the seventh, or about the seventh?

Hon. Mr. Timbrell: On the seventh? It's not dated. Well, there's a date at the back here, but I don't know if that's for the full paper. It's a different typewriter.

Mr. McClellan: The date on the back is May 29, but I don't know if that's the same date as the first 21 pages.

Hon. Mr. Timbrell: It's not the same typewriter, so that's why I'm not sure.

Mr. Chairman: Mr. Lawlor, on the point of privilege.

Mr. Lawlor: Obviously, the point being that a much truncated and reduced report was

submitted to this committee when it appears that another report, far more searching, with far more information on a number of things of which we were not cognizant or aware of at all, was in existence and available. And, damn it, it should have been handed to this committee. It might have foreshortened certain processes and we will have to spend some time on it today.

Hon. Mr. Timbrell: With respect, Mr. Chairman, am I not correct that the request to us had to do with the question of transfer of inpatients? Now, as I skim through this, the bulk of this is dealing with outpatient programs—the questions yet to be resolved about the existing outpatient programs, where they will finally settle and physical arrangements and so forth. So, with respect, we're talking about different things.

Mr. Lawlor: We're not talking about different things, with respect.

Mr. Kennedy: But inpatients. It says so, right at the top. Inpatients.

Mr. Lawlor: At all times we are concerned with the whole picture.

An hon. member: Not at all.

Mr. Lawlor: Are you saying you're not?

Mr. McClellan: You're not? I can't let that pass. There are major concerns about the relationship of the inpatients at Lakeshore to the inpatients at Queen Street. And it shouldn't come as any news to the minister that we're concerned about facilities for all of the inpatients within the catchment area, whether they're at Lakeshore or whether they're at Queen Street. So the report for me raises important questions with respect to the SOC unit for mentally retarded inpatients at Lakeshore; with respect to the child and adolescent unit at Queen Street; with respect to the inpatient component of the alcohol program; with respect to the capacity of Queen Street to absorb the psychiatrists who have been providing care to inpatients at Lakeshore and now seem not to have the right paper qualifications to work at Queen Street; and again the reference on the very first page to overcrowding unless the outpatient program is under what's called significant control of Queen Street. The report is related to inpatient services and the quality of inpatient services and those of you who are saying that it isn't should look at the report—it's unfortunate that you didn't—not the three pages.

Mr. Kennedy: The inpatients of Lakeshore Psychiatric Hospital.

[4:15]

Mr. McClellan: Yes, but not the three-page report that we were given, Doug—



**Hon. Mr. Timbrell:** Mr. Chairman, we are here today to answer questions.

**Mr. McClellan:** —21-page report which deals with important issues with respect to all of the inpatients in the area. And I am not talking about outpatients; I am talking about inpatients.

**Mr. Kennedy:** I don't know about that other report, but I know that this one—

**Mr. McClellan:** That's precisely the problem. Interjections.

**Mr. Chairman:** Mr. Conway has raised a point of privilege. The point has been made; members have discussed it. I think the point, from the committee members' point of view, is that they are concerned that there was information available with respect to the transfer of inpatients, and perhaps even beyond, that could've been made available to the committee and it wasn't made available. I think that point has been made.

The minister's response is that there was a document presented to the committee that was basically a summary of the original report, and, as far as the chair is concerned, I can't resolve the point of privilege. I think the point has been made and I think after that we should get on with the business.

**Mr. Conway:** It's my point of privilege; the minister has satisfied some of my questions as to what it was and where it came from. I would be happy to turn now to Mr. Lawlor whose initial point I interrupted.

**Mr. Lawlor:** The point that I had initially rose out of the minister's statement. The minister says, "I am advised by my professional and administrative staff that this point has now been reached." And this is the letter of May 31 to myself, and he has presented us with a series of letters, all dated June 13; one of them particularly, from Dr. Bond, which was the first one brought in, where Dr. Bond says he doesn't want to get involved in what he considers to be a political decision in this particular situation and his private view is the closing of the Lakeshore hospital was unfortunate and misjudged. And it goes on in that vein.

When the minister says he was advised by his professional staff two weeks previous to this, are these precisely the same people he is talking about? And then why the necessity after the event to extract, if I may put it that way, these numerous letters coming?

We have seen some instances of what I consider arm-twisting by the ministry on earlier occasions—

**Hon. Mr. Timbrell:** Mr. Chairman, the honourable member—

**Mr. Lawlor:** Let me finish.

**Hon. Mr. Timbrell:** Fine.

**Mr. Lawlor:** —with respect to the Queen Street medical staff on a particular occasion, and here again the minister, to cover his flanks some way or other, sees fit to proceed in this particular way. I'd like an explanation.

**Hon. Mr. Timbrell:** Mr. Chairman, I think that we are dealing with—

**Mr. Pope:** Call them.

**Hon. Mr. Timbrell:** I was just going to say I think we are dealing with men who are not about to have their arms twisted. They are all highly qualified professionals who are not going to be used for political purposes.

**Mr. Lawlor:** Well, the Queen Street staff would, and I'll say it bluntly.

**Hon. Mr. Timbrell:** But I would point out to you, letters from the leader of your party have been going out this last week apparently to administrators and staff at Queen Street and Lakeshore, trying to, in effect, involve them politically, and I wasn't going to raise that matter but I think it should be on the record that that's been happening.

**Mr. Breagh:** Who tabled this? The minister tabled this?

**Mr. Lawlor:** Yes.

**Mr. Breagh:** Could I just interrupt? I don't understand this. The minister tabled a letter from Dr. Bond before coming to the Legislature. Somebody is making an argument that he doesn't want these people to get politically involved, but the minister is tabling the letters here. I am a little more than three; I think I understand that when the minister tables a letter from somebody in here it's immediately political; it's put before a political body.

**Hon. Mr. Timbrell:** No, I thought we were here to talk about the needs of patients, and I don't consider that political. I want to make it clear.

**Mr. Breagh:** Oh, wait a minute.

**Hon. Mr. Timbrell:** I certainly do not.

**Mr. Breagh:** I think it's a little more than credible on your part. You are tabling information in here; we are supposed to be Goody Two-shoes, you are using the stuff for your political purposes. Are we supposed to sit here and take that?

**Hon. Mr. Timbrell:** No. Mr. Chairman, I want to make it very clear that the advice to me, and totally without arm-twisting, as you want to call it—because I think we are dealing with honourable people who are go-

ing to give their frank advice. And several of them couldn't be more frank as to the overall decision. I want to make it very clear that my concern is for the patients and their relatives and the programs, and the advice is that the moves planned for Wednesday of this week and August 1 must go ahead.

I fully acknowledge that the committee will make whatever recommendations they wish, looking ahead to the future, but I have to be guided by that advice, given the sanctioning, the go-ahead, with these moves. I am sorry you take that view but I certainly don't consider that political. I wanted to make the record very, very clear though, so that you wouldn't think that someone was trying to hoodwink you or anything.

**Mr. Breaugh:** Then where is your letter? Do you mean to say that in all of your staff you don't have somebody who says that it's a bad move and it shouldn't continue? And you are trying to get me to believe that everybody who's employed by the ministry these days believes, in the deepest of their hearts and on a purely aesthetic point of view, that the closing of Lakeshore is a good thing, empirically good?

**Hon. Mr. Timbrell:** One of the letters makes it clear that one individual thinks that the original decision was wrong.

**Mr. Breaugh:** That the original decision was wrong, but if I read it he says you simply have taken away all the staff so you have reached a point where you can't do anything else.

**Mr. Chairman:** Perhaps we could deal with the inpatient committee at this point. Mr. Conway had moved that the inpatient transfer committee appear before our committee here today, and Dr. Durost and Mr. McMullen and Dr. Bond, and Mrs. Latimer, and I guess Mr. Jappy who is involved in that committee, and Mr. Fisher, are all here today, and perhaps we should hear from them directly.

**Mr. Conway:** The member for Cochrane South suggested a moment ago that we do just that. I couldn't agree more, because I believe our time runs out at 6 o'clock tonight, and I really would like to put some questions to that group.

**Mr. Chairman:** Would it be preferable to have these people appear as a group, or do you wish to deal with them individually?

**Mr. McClellan:** As a group, I think.

**Mr. Chairman:** Yes, I think so. If we could arrange to have Dr. Durost, Mr. McMullen, Dr. Bond, Mrs. Latimer and Mr. Fisher, if you could congregate around some microphones there.

Does anyone want to make a statement, or would you prefer to deal with the questions of the committee at the outset?

**Mr. Kennedy:** Mr. Chairman, could we have the names from left to right? I presume the one on the left is Mrs. Latimer.

**Mr. Chairman:** Yes, that's right. Mr. Fisher, Mr. McMullen, Dr. Bond and Dr. Durost. Mr. Conway?

**Mr. Conway:** I would like to begin by asking a question of Dr. Bond, and I perhaps could use the evidence of the letter or the memorandum from Dr. Bond to the deputy minister, dated June 13, as a beginning point for what really was for me one of the essential questions I wanted to be assured of today. That is the reason why I moved that the committee appear.

I have heard a number of reports from people, staff and others associated with the Lakeshore facility about the impact of the discussions and the goings on in this committee. Can you, Dr. Bond, give us any very up-to-date evidence as to the morale as you see it among your professional colleagues, and more particularly, I suppose, the state of being of the inpatients at your facility?

**Dr. Bond:** I understand the question was, what is the state of morale of the staff?

**Mr. Conway:** Yes, two points. Are the delays, such as they have been described by ministry personnel and others, having a serious and negative impact upon the general condition of those employed at and institutionalized at the Lakeshore Psychiatric facility?

**Dr. Bond:** Yes, I'd have to say that. With the constant uncertainties, the morale is at a very low level, yes.

**Mr. Conway:** So there is no question in your mind that the inpatient transfers should take place on Wednesday of this week as per schedule?

**Dr. Bond:** Perhaps I could put it this way. The hospital has been a sort of political football. Either you have to save a hospital or close it. As the latter is inevitable, there is no point in prolonging the misery.

**Mr. Conway:** Are you convinced that there exists a reasonably sensible plan of transfer for these people from your point of view as the medical director at Lakeshore?

**Dr. Bond:** Yes. The transfer of the patients is a very simple matter. That's no problem.

**Mr. McClellan:** I don't know who wrote the so-called 21-page report entitled, Proposed Patient Services for the Lakeshore Psychiatric Hospital Catchment Area. Does

anybody in the group of witnesses know who wrote it or did any of the four of you participate in drafting this document?

**Dr. Bond:** No.

**Mr. McClellan:** Have any of you seen it?

**Dr. Bond:** Yes, we've seen it.

**Mr. McClellan:** I assume that since you didn't write it somebody in the Ministry of Health wrote it.

**Hon. Mr. Timbrell:** It was prepared by the staff.

**Mr. McClellan:** It was prepared by Mr. Jappy's office. I just hadn't understood.

**Hon. Mr. Timbrell:** I thought I had mentioned that.

**Mr. McClellan:** I must have missed that.

I want to raise a number of questions relating to concerns that are expressed in that document.

On the first page as part of the statement of rationale for outpatient programs and specialized services becoming a satellite of Queen Street, it says: "To prevent overcrowding of the Queen Street Health Centre inpatient services, it is necessary to have significant control over the outpatient services." Perhaps it would be appropriate for Mr. Fisher or Dr. Durost to explain what that means. It doesn't matter, which of you— whoever feels comfortable dealing with it.

**Dr. Durost:** It is a matter of planning a smooth pattern of admissions to inpatient care for Queen Street Mental Health Centre at the time we assume responsibility for the Lakeshore catchment area. In our view, that's absolutely essential when we assume responsibility for patients being admitted to the hospital, particularly for the major Lakeshore catchment area. In the case of the outpatient programs that exist on the campus of the Lakeshore hospital, it would be preferable that they be administered by the same group. In this case, as medical director of Queen Street Mental Health Centre I would be responsible for them. Then the outpatient programs on the campus at Lakeshore Psychiatric Hospital would be like the other programs.

In that position, I would be able with the staff to create policies and procedures that would permit a smooth process of admission to Queen Street and, at the time the patient needed discharge, a smooth transfer to the appropriate outpatient program needed by them for their ongoing care. If that were between two facilities, it would mean it would be necessary to discharge a patient from Queen Street and admit the patient to another facility involving an enormous

amount of paperwork and probably a great waste of staff time in the inevitable procedural negotiations that otherwise could be virtually totally avoided.

**Mr. McClellan:** At the other end of the question is there a concern that if there is a malfunction in the outpatient programs, you are going to be getting readmissions to inpatients?

**Dr. Durost:** We anticipate readmissions in any event since, unfortunately, that is one of the aspects of the lack of total success in psychiatric treatment. What we are mainly concerned about is the availability of smoothly functioning outpatient programs to which we have immediate access by virtue of a joint supervisory relationship between the staffs and outpatient programs. It's pretty much a sine qua non. It's virtually impossible to operate a large inpatient program and an even larger outpatient program with split responsibilities.

[4:30]

**Mr. McClellan:** That's helpful. Has that control been established? Or have you assumed administrative control over the—

**Dr. Durost:** Not yet.

**Mr. McClellan:** What's the time line for that?

**Dr. Durost:** The date has not yet been established, but on the basis of frequent contact in the program planning committee for this process, which I chair, the staff of the Lakeshore Psychiatric Hospital and Queen Street Mental Health Centre meet at the moment even more than once a week in order to work through the procedures we have to follow for a smooth transfer of inpatients and setting up the necessary mechanisms for return to outpatient programs.

**Mr. McClellan:** How long will it be then, assuming that things go as scheduled?

**Dr. Durost:** If this goes as scheduled, we will start to admit from the Lakeshore catchment area, other than what we've already started to admit from west North York, and we'll take over Etobicoke and Peel region as of midnight, June 19. We'll take the inpatients from units three and four to which I referred in my letter as being the most acutely ill, and there's a transfer of the patients from A and B, who are longer term patients, to Queen Street, by August 1. By that time we will have presumably set up the necessary mechanisms for Queen Street to assume responsibility for the outpatient programs on the Lakeshore campus.

**Mr. McClellan:** I assume that there will be a block of psychiatric staff coming over on



June 20 with the ward three and four patients.

**Dr. Durost:** There will be 48 to 50 nurses; I believe six psychiatrists; and I haven't got the exact details on the numbers of social workers, occupational therapists, psychologists, and so on, but we will be opening 68 beds on June 20.

**Mr. McClellan:** You will be opening 68 beds?

**Dr. Durost:** Yes.

**Mr. McClellan:** How many beds are open right now?

**Dr. Durost:** 458.

**Mr. McClellan:** Oh. So you'll open them up as the patients come?

**Dr. Durost:** The patients will be on their way on Wednesday morning. The wards will be staffed. Clinical records will be transferred, and we will be ready to accommodate those patients and to admit new patients being referred to the centre from the Lakeshore catchment area on the same day. These moves have to occur simultaneously.

**Mr. McClellan:** The doctors who are coming over from Lakeshore I gather are—according to page two of this proposed patient services report—not suitable? What is the correct phrase I'm searching for? They don't have the correct paper qualifications to work at Queen Street?

**Dr. Durost:** Among the medical staff at Lakeshore Psychiatric Hospital there are some members who have not obtained their certification in psychiatry from the Royal College of Physicians and Surgeons.

**Mr. McClellan:** How many?

**Dr. Durost:** Five, perhaps.

**Mr. McClellan:** Out of how many?

**Dr. Durost:** I'm not sure. I think five out of about 15.

**Dr. Bond:** Who don't have their fellowship? I think there are about seven altogether.

**Mr. McClellan:** Out of fifteen? Almost half.

**Dr. Bond:** It always was about half.

**Dr. Durost:** This, as you know, presented a problem for the Medical Advisory Committee of Queen Street Mental Health Centre in the context of its letter of agreement with the University of Toronto, which requires that psychiatrists on the staff at Queen Street be certified by the royal college. We have worked this through in meetings with the staff, our staff, and with the university and the committee is prepared to recommend the appointment of all of the medical staff at the Lakeshore Psychiatric Hospital to the medical staff of Queen Street Mental Health Centre,

with the proviso that those who still maintain their eligibility to write the Royal College of Physicians and Surgeons certification examinations do so and obtain their certification. For those who have lost their eligibility and who require an additional year of residency training, this has been negotiated with the University of Toronto's department of psychiatry and arrangements will be made for them to do that.

**Mr. McClellan:** To take their residency?

**Dr. Durost:** They are classified as clinical fellows and for a year they are given the opportunity to participate to the fullest extent in all the training programs we currently provide for residents in the regular department of psychiatry diploma program.

**Mr. McClellan:** What duties will the non-certified psychiatrists be performing? I gather they're going to be employed as physicians, rather than psychiatrists.

**Dr. Durost:** No. They would be employed as psychiatrists, but under supervision during this period of training, in the same sense that we provide supervision for residents in training.

**Mr. McClellan:** I have a couple of questions I wanted to ask about the three remaining inpatient programs. Again, I'm not sure how to categorize it. I don't know whether they're remaining at Lakeshore Psychiatric Hospital for very long or whether there are imminent plans for moves. I'm referring to the social orientation unit, the child and adolescent program and the alcohol program.

Perhaps Dr. Bond could help me on the first of those, the social orientation unit. What is the fate of that service?

**Dr. Bond:** According to the information I have it's due to be transferred to Whitby Psychiatric Hospital, prior to September 1.

I understand that all inpatient services, other than the children's unit which is run by the other ministry, are supposed to be off the grounds by September 1.

**Mr. McClellan:** So the assumption is that the SOC unit will be transferred to Whitby by—

**Dr. Bond:** September 1.

**Mr. McClellan:** —September 1.

One of the goals of the SOC unit listed in the patients' services report reads as follows: "To help community agencies, family and friends implement appropriate interventions."

How many of the people who are in the SOC unit are from the Metropolitan Toronto area?

**Dr. Bond:** If you talk about the greater Metropolitan area, I suppose probably most, if not all of them.

**Mr. McClellan:** Do you have a breakdown of those who are from the Metropolitan Toronto region and regional municipalities?

**Dr. Bond:** We have that. I didn't bring it with me. Some are—

**Mr. McClellan:** A relatively high percentage?

**Dr. Bond:** Oh, yes. Some of them are MTMR referrals and some are not.

**Mr. McClellan:** Do you know how many are MTMR referrals? That's the Metropolitan Toronto Association for the Mentally Retarded.

**Dr. Bond:** I'm not sure of the actual number.

**Mr. McClellan:** A high percentage? I don't need the precise figures. They can be obtained later.

**Dr. Bond:** I think Dr. Morin said the other day it was about six or seven. I'm not sure.

**Mr. McClellan:** Six or seven patients?

**Dr. Bond:** But I may be wrong.

**Mr. McClellan:** Out of how many?

**Dr. Bond:** Out of 45. There are usually about two vacancies—43, I guess.

**Mr. McClellan:** Is it possible to achieve the goal of helping community agencies—

**Dr. Bond:** Excuse me. I'm sorry. I'm getting mixed up with another ward. There are 26 beds on SOC, not 45; I'm thinking of B. But I believe there were two admissions today from MTMR, so it's probably a bit higher.

**Mr. McClellan:** Do you think it's possible to achieve the goal of helping "community agencies, family and friends implement appropriate interventions" when the inpatient facility is at Whitby, rather than in the people's own community?

**Dr. Bond:** I suppose they could carry on. There's just the inconvenience of the distance.

**Mr. McClellan:** I suppose they'll have to carry on.

The disposition of the child unit is still not sorted out, is that correct?

**Dr. Bond:** I don't know.

**Mr. McClellan:** The children and adolescents unit.

**Dr. Bond:** This will be subject to negotiations above our head between the two ministries. I don't know what arrangements will be made.

**Mr. McClellan:** Right. The alcohol unit—I gather from the patient services report that the intention is to turn it into an outpatient services program. Is that your understanding?

**Dr. Bond:** Day care and outpatients, yes.

**Mr. McClellan:** Right.

**Mr. Chairman:** Mr. McClellan, did you want the minister to comment with respect to the negotiations between the two ministries?

**Mr. McClellan:** Yes, if he could help us out.

**Hon. Mr. Timbrell:** How many years is it now since ComSoc set up the community board for that unit—about three years? They've been discussing with them for some time the question of divestment and where it would actually end up. As I understand it, for the immediate future it will be staying on site and ComSoc will be arranging various backup services of food and so forth until such time as they do find a site for it.

**Mr. McClellan:** Do they have any assurance of a long-term facility at Lakeshore? What's the story there?

**Hon. Mr. Timbrell:** As long as they need that. As I said last time I was here, no service will be put into a position of having to be interrupted for a period of time until such time as an alternative is found. They will carry on at Lakeshore.

**Mr. McClellan:** Maybe you could respond as well to the alcoholism program. When we were out there talking to Dr. Maharaj he was quite insistent that the inpatient component was an essential component of the program. I don't understand why we're not leaving an inpatient component right there at Lakeshore rather than trying to negotiate an inpatient facility at St. Joseph's Hospital.

**Hon. Mr. Timbrell:** As I recall it—I'm going back some time now; perhaps as long as a couple of months—it was acknowledged in discussions with Dr. Maharaj that the program could function as a four-week, day-care, outpatient program. As I understand it, that would be on the basis of the first week, a full seven days, and the following three weeks, Monday to Friday from nine till nine, a 12-hour day program.

You may recall that when we discussed the matter here—I've lost track of the dates—I pointed out that in fact a very small number of the patients who have been looked after in what presently exists as a three-week outpatient program have actually come from the detoxification element, the inpatients. It was, as I said, acknowledged that it could operate as a four-week outpatient program as long as we make arrangements for a detox unit.

We've had money set aside for several years now and have been trying to find an appropriate location for a detox unit in Etobicoke. Up until now the only interest that's been shown, as I understand it, has been in the north end of Etobicoke, which is not where

the need is. That's why I directed the staff to approach St. Joseph's, since it is so close to the heart of the community. They have apparently expressed an interest as long as, obviously, the money is there to fund it, [4:45]

**Mr. McClellan:** I don't understand. You have an excellent program running. Everybody concedes its excellence. I know it's used extensively by people that I talk to—for example, at the United Steelworkers, their Lifeline project.

**Hon. Mr. Timbrell:** This won't stop access by them.

**Mr. McClellan:** It is used by Massey-Ferguson in my riding in its employee assistance program. It seems to me that you've established administrative control at Queen Street of a program, part of which is a satellite on the Lakeshore site, and another part is going to be on a third location in St. Joseph's Hospital. I don't understand why you don't simply keep that thing together.

**Hon. Mr. Timbrell:** Because the inpatient component—and perhaps Dr. Durost or others may want to comment—is not in fact an essential part in as much as so very few of the people who are in the program, graduates so to speak, or alumni came through the detox unit. Nothing in what's being proposed will in any way infringe on or impede the access by local industry, and I commend them for having the enlightenment to be working with their employees and using such a service for alcohol problems.

**Dr. Bond:** If I can say something, I think there's some confusion here. There are three programs in the alcoholic unit. The first one is the elective one, which these companies use. That at the moment is a one-week and then a three-week day care, and that's going to be turned into a four-week day-care program. One week inpatient, three weeks day care and then they go on to outpatients for a year.

The second component is what you refer to as a detox component. These are not elective. These are alcoholics who turn up at our door, and that is a service for any alcoholic who comes to the door. That's the program that is scheduled to be turned over into a community detox centre.

The third component is the outpatient department.

**Mr. McClellan:** Yes, but what happens to the one-week inpatient component of the elective program, which is the program which is receiving referrals, for example from Lifeline or other employee assistance pro-

grams within industry? You're turning it into an outpatient program without any inpatient component, if I understand correctly. When we were out there as a committee to talk to Dr. Maharaj, he talked about the absolute importance of having the inpatient component as a way of imposing a kind of regimen of discipline on some very undisciplined characters, and he saw it as a very important feature of the program.

I don't know why you are fooling around with that, if I can use the expression, because I don't know how else to describe it.

**Hon. Mr. Timbrell:** Let me ask Mr. Jappy to comment, because I certainly don't intend to fool around with any of these.

**Mr. Jappy:** No. There were concerns expressed about the fact that we had a detox unit in a psychiatric hospital. All other detox units in the province function outside of a hospital setting. They've had a considerable amount of success running them just as they run the one on Ossington Avenue, Knox Avenue, and another one in the Toronto area, and they usually use reformed alcoholics to keep the program running. They know all the signs. They know all the problems. They've done an excellent job. They have to be provided with backup from a general hospital, and invariably the general hospital supplies one hot meal a day, laundry, administrative services, et cetera.

So we're not proposing something radical for this particular program. All we're proposing is that it go into the community, where it's accessible to more than just the people who know where Lakeshore Psychiatric Hospital is. It would be backed by St. Joseph's Hospital, just the same as the other detox programs in the Toronto area, and it would function in that manner.

We had a committee to review the program, and I'm sure you got the report. I think I saw it being passed around some time ago. This committee indicated that it felt very strongly that the detox portion of the program should be moved outside of the psychiatric hospital, not necessarily to be consistent, but it was a better method of treatment because a lot of these people who had come into the detox unit have no intentions of mending their ways. As a matter of fact, I think right now only about 15 to 20 per cent after their third or fourth admission have any inclination to proceed on to Alcoholics Anonymous or an elective program, or so on.

**Mr. McClellan:** That begs the question of why you are removing the inpatient component from the elective treatment program. You're willing to concede that the detox



client population is a very difficult group and you get a very small number of people graduating from the detox into the regular program, but you get an awful lot of people in Dr. Maharaj's unit going into the elective program, taking the one-week inpatient and the three-week outpatient treatment. It seems to me that what you're doing is destroying the program by removing the capacity to provide a one-week inpatient treatment component.

**Mr. Jappy:** Not necessarily.

**Mr. McClellan:** Where are they going to go? Are they going to go to the detox unit?

**Mr. Jappy:** No. During the first week they're going to be there for approximately 12 hours a day and then, just as they do in the other three weeks, they will go home at night and come back first thing in the morning, and that happens for the first week for seven days. I think the committee also made some remarks with regard to that and felt it wouldn't harm the program in any way.

**Mr. McClellan:** I don't agree with you. I think that a drying-out period is an essential component of any alcohol treatment program and if you have guys being referred from Lifeline into the program and they don't have that regimented discipline imposed—

**Hon. Mr. Timbrell:** Like you, I'm not an expert on these kinds of programs—

**Mr. McClellan:** I've had a little bit of experience from my own background with addiction counselling.

**Hon. Mr. Timbrell:** But as I recall, the group that did look at the program and made these comments was made up of people from the Addiction Research Foundation—from the Clarke Institute?

**Mr. Jappy:** Yes.

**Hon. Mr. Timbrell:** And where else?

**Mr. Jappy:** From the ministry, and I believe the director of research and education from Queen Street was on that committee as well.

**Mr. McClellan:** I think you're going to have problems. I talked to a guy like Lloyd Fell, whom I see quite a bit, and he praises that program to the skies. One of the things he likes about it is the fact there's that inpatient week where the guy can go in and dry out and get used to some very basic disciplined routines before he goes into the outpatient part of the program. We have sufficient grounds for alarm about the paucity of alcohol treatment programs in this community and in the province, and there are a number of things that are more appropriately dealt with in estimates than

here, but when you have an excellent program operating, I just don't understand—

**Hon. Mr. Timbrell:** But do you appreciate that even with a one-week inpatient component there is no way to force the individual to stay on the grounds?

**Mr. McClellan:** Yes, I understand that.

**Hon. Mr. Timbrell:** The individual is free to leave the grounds at any point.

**Mr. McClellan:** Yes, it's an elective program.

**Hon. Mr. Timbrell:** That's right. They're voluntary.

**Mr. McClellan:** Of course I understand that, but I also know that a guy who comes into the program from Lifeline has—I mean, he's at the end of a rope and if he does go out he faces job loss, probably loss of possibility of grievance against job dismissal, et cetera, so the pressures on him are enormous.

**Hon. Mr. Timbrell:** Which would be the same pressures or incentives to—

**Mr. McClellan:** But he also needs a lot of help. I just think it's nuts.

**Mr. R. F. Johnston:** That's right. It's something that works, why change it? If you've got something that works, and it obviously works, and the directors are committed to it, why change it? It just doesn't make sense to me at all.

**Mr. McClellan:** I won't take too much more time. I just had one other thing I wanted to raise. There's a reference in the patient services report on page 21, in a section entitled "Other Outstanding Issues." One of these is the Queen Street adolescent unit, and I'm not sure what its fate is. Perhaps Mr. Fisher or Dr. Durost could enlighten the committee on what's happening with that unit.

**Mr. Fisher:** This has been under discussion by the two ministries for quite some time. I haven't been directly involved, but my understanding is that the inpatient component will be transferred to Whitby, although I'm not absolutely certain. Perhaps Dr. Dyer or the minister could comment more certainly on this.

**Mr. McClellan:** If there is somebody who knows, perhaps they could share it.

**Dr. Dyer:** We have had discussions with the Ministry of Community and Social Services, which is fully in agreement with moving this unit to Whitby prior to September 1. There are facilities at Whitby to accommodate that unit. It will be then combined in the same sense with the move from the social orientation unit. It's more or

less in the same program. They'll be combined at Whitby.

**Mr. McClellan:** Queen Street won't have the capacity to provide psychiatric care to adolescents?

**Hon. Mr. Timbrell:** My understanding is that ComSoc has been talking with the staff of this ministry for several years about moving out of Queen Street.

**Mr. McClellan:** I didn't think that Whitby was part of the discussion.

**Hon. Mr. Timbrell:** It has certainly been one of the options considered in the last five months since the decision to close Lakeshore.

**Mr. R. F. Johnston:** Ironically, there was so much room there for the move to Queen Street and now all of these things are being moved out to Whitby all of a sudden. It's kind of amusing.

**Hon. Mr. Timbrell:** There is only one unit moving from Queen Street.

**Mr. R. F. Johnston:** Then one thing from Lakeshore which we might have presumed either would stay on the grounds or go to Queen Street is going to Whitby too.

**Mr. McClellan:** What is the reference in this same report to one of the two other outstanding issues, that is, to a study of mental health care needs in greater Metropolitan Toronto? Is that something that's under way?

**Hon. Mr. Timbrell:** The title looks familiar. I think that arises out of a motion that was put at this committee by the member for Renfrew North. Is that right?

**Mr. Jappy:** I believe so.

**Mr. McClellan:** Could you give us some details? Is it something that has already been commissioned? Is the work under way?

**Hon. Mr. Timbrell:** No.

**Mr. McClellan:** Is the work being completed?

**Hon. Mr. Timbrell:** No. It's an outstanding issue to be considered in the light of the motion put by Mr. Conway several weeks ago, which included the suggestion of such a study. I had indicated two months ago that a further review some time in the next five to 10 years should be carried out. That's something for future discussion.

**Mr. R. F. Johnston:** On that, it's my understanding from speaking to someone yesterday that in point of fact a review of services in Metro Toronto has just been completed recently and that you have it on hand.

**Mr. Jappy:** No, we don't.

**Mr. R. F. Johnston:** The person I talked to had worked on it.

**Hon. Mr. Timbrell:** What it might be—and this predates your coming here so you perhaps are not aware of it—is this. Two years ago last March, I asked the Ontario Council of Health, which is the senior provincial advisory body on health matters, to look at the Mental Health Act and also at mental health services and to conduct a review. They've held meetings all around the province. It may well be that someone known to you has worked on a paper for the council relating to Metro. I don't know. We've not received the report yet. It's apparently in the final stages of discussion by the council of health. They've had reports from their task force and the professor, Abbyann Lynch, and we should get it in the next couple of months, I would think.

**Mr. Jappy:** I think Mr. Johnston is talking about another report that has been commissioned by ComSoc with regard to children's treatment in the four-phase system in Metro. Is that correct?

**Mr. R. F. Johnston:** No. As I understand it, it has to do with community services in mental health.

**Hon. Mr. Timbrell:** Is that children's mental health?

**Mr. R. F. Johnston:** I don't think so because children's mental health has been with ComSoc for two years. I understood it had to do with your ministry. That was the way it was put to me. I can't remember the unit exactly. [5:00]

**Hon. Mr. Timbrell:** If it's in connection with the council of health paper, then we'll know in a couple of months at the most.

**Mr. Conway:** You don't need to worry about that, because if that's given the same attention as the recommendations—

**Mr. R. F. Johnston:** On McKinsey.

**Mr. Conway:** —on Bill 19 they will be academic only.

**Mr. Chairman:** Mr. McClellan?

**Mr. McClellan:** No further questions.

**Hon. Mr. Timbrell:** Surely you would reserve to yourself, as somebody who would like to be Premier some day, or at least a minister, the right to disagree. As you recall, a year ago I disagreed.

**Mr. Conway:** I know, I recognize that entirely.

**Mr. Chairman:** Mr. McClellan?

**Mr. McClellan:** I have no further questions.

**Mr. Chairman:** Mr. O'Neil?

**Mr. O'Neil:** Thank you, Mr. Chairman. I think what we are really here for today is to find out whether or not these gentlemen and this lady more or less agree that these pa-



tients should be moved from one hospital to another. In your comments, Mr. McMullen, you mention the morale of the staff at Lakeshore. Who do you mean; the staff who are moving or the people who are not being rehired?

**Mr. McMullen:** I mean the residue, the staff that is still there.

**Mr. O'Neil:** Are these people, though, who will not be going to Queen Street?

**Mr. McMullen:** To a large extent that is correct.

**Mr. O'Neil:** So in other words the morale among these people, on the way the patients may be—

**Mr. McMullen:** Morale has fallen way off. Many of the staff are leaving to seek other employment. It's becoming virtually an untenable situation to continue to run the hospital; therefore, I recommend that the patients be moved as quickly as possible.

**Mr. O'Neil:** I notice that the letter the minister sent out said, "As I have indicated in our conversation I have no choice but to be guided by this advice," meaning the advice that he would get from people like yourself; but of course what I think we have to look into as well is whether he is being guided by your advice or you are being guided by his advice. I notice all of the letters that came from you gentlemen are dated June 13, 1979. You were asked to submit these recommendations but was anything added to that? In other words, some suggestion we've got some problems here but we don't have your support; or we have this thing falling apart, or political problems or anything like that?

Could I ask you first, Mr. McMullen, was this the vein of the question or the call; were you left free to give your own advice?

**Mr. McMullen:** I believe I would have written the letter whether or not I had been involved. The situation had become so dicey in the hospital.

**Mr. O'Neil:** Dr. Durost, what about you?

**Dr. Durost:** The communications to the ministry were of a verbal nature over a period, particularly when the last planned transfer was abruptly postponed. I shared with Dr. Bond and my own staff, and staff at Lakeshore, very serious concerns about the impact on the patients who were all packed and ready to go, and the staff and relatives in the community. I expressed quite strongly that this simply could not happen again. I can't make that statement any clearer.

This was an opportunity to put it in writing, but I had certainly made the statement

verbally many times; certainly immediately after this last postponement, I was appalled.

**Mr. O'Neil:** When you're saying this couldn't or shouldn't happen again, in other words to the extent it has now with this indecision as to whether or not they are going to move, do you totally agree with the way this whole thing has been handled by the ministry? In other words do you feel there was enough consultation with yourself and with other members of your staff so you could be properly prepared to accept these patients; or would you like to have seen it handled in a little different way? I realize I may be putting you on the spot; but again the last thing we want is to have something like this happen again.

**Dr. Durost:** As I'm sure you understand, once the closure of Lakeshore was announced we immediately formed appropriate committees to implement the decision and jointly with the staff of Lakeshore Psychiatric Hospital we have been proceeding with this. As I mentioned earlier, there has been a program planning committee that has met weekly; plus an inpatient transfer committee, outpatient committees and so on. We have been planning as rapidly and effectively as we could, but that planning process is extremely difficult when you're all prepared and set and everybody's ready to implement the plan and then it is suddenly and abruptly stopped. This is untenable.

**Mr. O'Neil:** You're saying "as you could," so between the time of the political decision to close it and the time, in other words, you were prepared to move these patients, do you feel you should have had more time to prepare for some of these things that have—in other words, there should have been more preparation? Because you did say "as you could."

**Dr. Durost:** Ideally in a move as major as this one would like to have a great deal of time to plan. But there are, as I understand it, limitations on the amount of time that can be made available; limitations that are certainly not subject to the jurisdiction of the staff in either hospital.

**Mr. O'Neil:** I'm not trying to put words in your mouth, but maybe I should ask you and some of the other gentlemen too if there should have been more lead time between the time the announcement was made and the time you were ready to accept these patients.

**Dr. Durost:** My problem is that I am not aware of the options available.

**Mr. O'Neil:** I see: What would you say to that, Dr. Bond?



**Dr. Bond:** Could you rephrase that question?

**Mr. O'Neil:** In other words, do you feel there was enough time between the decision made to close the hospital and the actual time that you would have initially accepted these patients—not accepting them now, but the initial acceptance of them? Should there have been more time for preparation at Queen Street and also at Lakeshore?

**Dr. Bond:** I suppose there's sufficient time to move inpatients, but I don't think there's sufficient time to organize some sort of community outpatient network. That takes ages.

**Mr. O'Neil:** Are you then, Dr. Durost, saying that in other words you don't feel there's any problem accepting these inpatients at Queen Street; that you are prepared to handle them; that you do have room for them; that they will be looked after properly?

**Dr. Durost:** Yes.

**Mr. O'Neil:** Could I ask that of Mr. Fisher?

**Mr. Fisher:** I have personally complained because these projected plans have been delayed. Staff get poised to implement the plan, the patients are advised the plan is to take place, then when they've been stopped on a couple of occasions, this has been most disruptive. We've been fully planned; we were fully prepared to accept the inpatients. We could have made this transfer weeks ago, and from my standpoint it would have been better had we done it weeks ago.

**Mr. Conway:** Could I ask a supplementary, Mr. Chairman? This is probably an appropriate time to get Mr. Fisher to comment. One of my colleagues last week expressed a very serious concern about an article which appeared in the Toronto Sun, dated Monday, June 11, in which it was alleged that a fatality had occurred in the Queen Street area of Toronto, I believe, wherein an inpatient at the Queen Street facility had walked out, stolen a car, and then had been involved in a fatality on the street.

I don't know whether you wish to comment on that, but one of my colleagues involved in this debate was concerned that perhaps there was something here that we should hear about. Is there anything outside of that story that is relevant, or is it something that is possible at all times?

**Mr. Fisher:** It's certainly a tragic situation. The matter is under investigation. I have asked Dr. Durost to form an investigating committee. I couldn't make any comment other than that, because we really don't know what the facts are.

I would like to tell you that this is a clinical matter and has to be investigated by clinicians

who understand whether or not we have maintained our standard. This is what we're looking at now.

**Hon. Mr. Timbrell:** The police are also investigating.

**Mr. Conway:** The concern of one of my colleagues was that perhaps there may be some relationship between this and the overcrowding or whatever that was the concern expressed in this connection earlier. I just open it to you for a comment. I appreciate what you have said. If there is nothing further, that's—

**Mr. Fisher:** It's highly unlikely.

**Mr. O'Neil:** Of course, one of the main concerns—this besides patients, who are the most important concern—is the problem that people who are going to lose their jobs at Lakeshore may not have other work to go to. Have you really given a fair amount of consideration to hiring as many people as you possibly can, so these people do not go without jobs?

**Mr. Fisher:** One of the first things we did, after the honourable minister made his announcement, was to prepare a budget which outlined our needs. We didn't go beyond that, because that was what we were asked to do. I wouldn't presume to prepare a budget which would have as its objective to make jobs or make work. I don't think that's my job. So, that's what we've done; we submitted that budget to Mr. Jappy. Any other decisions are in Mr. Jappy's area and not in mine.

**Mr. O'Neil:** I wonder if I could ask Mr. Jappy, have you any idea how many people will be left without jobs at Lakeshore? Are you going to be able to place some of these people in other hospitals, or other areas of the ministry that, you know, are not responsible?

**Mr. Jappy:** Well, I believe, initially, there was something like 240 layoff notices sent out. That has been considerably reduced now by many factors—people taking jobs in general hospitals, jobs in other ministries. I believe we have posted 504 jobs at Lakeshore since the closure was announced and I think we still have something in the neighbourhood of 130 layoff notices pending. I see one of the union members nodding her head.

I think we go over the list every two weeks almost religiously and that's the situation we're at right now. Naturally we would like everybody to be placed. Obviously, our aim is to do the best we can under the circumstances.

**Mr. O'Neil:** A final question, Mr. Chairman, and I want to address it to Dr. Bond. I certainly have a fair amount of respect for Dr.

Bond, that he may be bucking against the winds when he comes up and he says, "I still hold my private view that the closing of Lakeshore Psychiatric Hospital was unfortunate; unfortunate and misguided." I wonder if you could just expand a bit on what you mean by "misguided."

**Dr. Bond:** We sat in here for three weeks going over all this. I guess, as things turned out, I might as well have been telling nursery rhymes because it obviously doesn't seem to matter what you say. It's simply my private opinion that in an area with the population increase you have out there—and Peel itself has increased by 27 per cent in the last four years—one should have at least a small hospital; maybe not a big hospital, I don't like to see hospitals get too big. That's one reason.

Also, the city is spreading west—the core of the city is emptying so it seems strange to bring it all down into one big hospital in the centre of the city. Plus, of course, there is the inconvenience to the staff, as well as to the relatives, families, police and so on, in getting emergencies from up in Mississauga somewhere down into Queen Street.

I have no doubt this must be a great burden to Queen Street, to have to suddenly engorge a hospital with admission rates slightly higher than they had already. It's rather like a snake sort of having to swallow another snake a little bit bigger than itself, so it would obviously lead to difficulties, I would think.

**Mr. O'Neil:** Are you going to Queen Street yourself?

**Dr. Bond:** No.

**Mr. O'Neil:** You're not. I was going to ask you whether you feel that Queen Street—but if you're not going there I guess you wouldn't know whether or not—

**Dr. Bond:** Well, I can't speak about Queen Street; we have a representative here.

**Mr. O'Neil:** Right. Okay, thank you, Mr. Chairman.

**Mr. Lawlor:** Just on the morale of the situation, Dr. Bond. You say, "However, the hospital cannot operate without support staff and these support staff are continually being eroded to a point where it will not be possible to continue to operate." My question is, certainly, this ongoing, constant erosion of staff—seeing people disappear—is a major factor, I would put it to you, in the position on morale; do you agree?

**Dr. Bond:** Well, yes. I'm sorry, maybe I misunderstood your question. Are you saying that the erosion of the support forces—

**Mr. Lawlor:** Of the staff—the disappearance of their compatriots from the hospital has a detrimental effect upon the morale.

**Dr. Bond:** Well, it does. It's a very depressing place to work at right now.

**Mr. Lawlor:** And that goes a long way to explaining why the present malaise exists, do you agree?

**Dr. Bond:** Well, yes, but a hospital isn't just composed of doctors and nurses, it's a total organization. You rely on the support forces, who are just as necessary as the rest, so if that component goes, you reach a point where you're in a terrible mess.

[5:15]

**Mr. Lawlor:** Then it has an immediate repercussion upon the patients, of course, too.

**Dr. Bond:** Yes.

**Mr. Lawlor:** In the 21-page report, at the bottom of the first page, it says: "To prevent overcrowding at the Queen Street Mental Health Centre, inpatient services, it is necessary to have significant control over the outpatient services." Would someone care to expand upon that? Just what significant control is envisaged in this situation?

**Dr. Durost:** Mr. Chairman, would you like me to read my earlier comments?

**Mr. Chairman:** Yes, Dr. Durost.

**Dr. Durost:** The problem is one that was already encountered in Britain, for example. At one time in the development of the National Health Service, they split outpatient services from inpatient services and placed them under two separate jurisdictions. They have subsequently reversed that, and recombined them. This was because the experience was that a hospital that was responsible for the inpatient component of patient care must be in a position to have ready, free access with the minimum of administrative obstacles to the free movement of patients from one modality of a care to the other, or to another.

In hospitals like the Queen Street and Lakeshore, a single patient may move from outpatient status to inpatient status to day care, to aftercare, back to inpatient status. It's a dynamic that would be seriously undermined if it were necessary to go through inappropriate administrative obstacles. In my view, it would interrupt that free flow of patients and would have a deleterious effect on our ability to deliver proper care.



Consequently, it was recommended that the outpatient services on the campus at Lakeshore Psychiatric Hospital should be organized in such a way that administratively they would be supervised by the clinical administrative staff at Queen Street.

**Mr. Lawlor:** Would it mean that with the inundation that could be anticipated with respect to outpatient services, the time taken, and the number of people who will require to be hospitalized as a result of that flow, this is going to tax your facilities to the limit?

**Dr. Durost:** I would think that in the absence of well-organized and integrated outpatient services the possibility might well exist. This point was made on a number of occasions in the earlier sessions of this committee by a variety of people.

**Mr. Lawlor:** You wouldn't dream of turning outpatients away in order to relieve tensions in the Queen Street Hospital?

**Dr. Durost:** No, sir.

**Mr. Lawlor:** All right. In the social orientation unit, in prolongation of what Mr. McClellan had to say about it—Mr. McClellan quoted certain portions of page six of this document. But then, when you set up your objectives, and there are a whole series of them, number five is "to meet with the patient and family for the purpose of sharing information, problem identification, support, and bringing about changes." And number six, "to provide monthly meetings for relatives and friends of the patient"—for the friends of the patient—"for the purpose of discussing educational material useful in understanding better ways of meeting the needs of the mentally handicapped, and provide conferences at the hospital or in the community." It goes on in that vein.

Nevertheless, in moving it out to Whitby I find there's some discrepancy in those two. How can you provide those services to the mentally retarded which editorials in newspapers and others have brought forward in the past as being critical, yet at the same time make this particular move? I throw the question to whoever wishes to answer it.

**Mrs. Latimer:** I think the Metro Toronto Association for the Mentally Retarded also serves the Whitby community as a crisis centre. Actually, we at Lakeshore had served the two areas, so some of the patients in MTAMR come from Whitby.

**Mr. Lawlor:** A very considerable number of patients come from the Lakeshore or from the Metropolitan Toronto area as such.

**Mrs. Latimer:** That's true, sir, but I have found with about 26 beds we have a re-

current turnover of six approximately, for the crisis centre.

**Mr. Lawlor:** I'm putting it to the minister that that is a blunder and that you should reconsider that particular position. I don't want to take a great deal more time. We haven't got much.

**Hon. Mr. Timbrell:** I may say, Mr. Chairman, we've discussed with MTAMR the same kinds of reservations about travel and recognition of the various facts such as Mrs. Latimer has already described, as to where the people who are at Lakeshore now are coming from. MTAMR have written a letter indicating support, I guess, if that's the right word, and appreciation for the co-operation of the ministry over the years in creating a crisis intervention unit in the first place. We have really done a great deal to assist the MTAMR in providing a service that previously didn't exist.

**Mr. Lawlor:** All I'm doing in this questioning at this late date is simply highlighting certain decisions or positions taken by the ministry, so that when the chickens come home to roost, we'll be able to point them out to you. I have no doubt in my own mind that, in numerous areas here, the chickens will return.

Let's talk about the alcoholics unit for a moment—again, it's so late in the day. If I had my way I would call Dr. Maharaj before this committee and have his personal opinion about the matter. From the time we visited the hospitals and the conversations we've had, I think he can hardly give much credence to what you're doing there with respect to this very special kind of detoxification unit, with its 20 beds and with its program.

This government gets \$1 million a day from the sale of alcohol and you can't afford to keep 20 beds at a hospital so people can dry out for one week. I think this is a disaster and a crying shame.

**Hon. Mr. Timbrell:** With respect to the honourable member, nobody's talking about doing away with the detoxification unit and process.

**Mr. Lawlor:** I'll come to that in a minute. I'm saying when it's worked in conjunction with the inpatient unit, it has a particular validity. It's quite different to any other detox unit—we all know Dr. Maharaj's opinion of these detoxification units divided from the kind of care and hospital situation he can provide. Sure, you're going to talk about St. Joseph's Hospital. I put it to you bluntly that St. Joseph's Hospital is loaded to the doors as things presently stand. They



have no space, room or any capability to make provision for a detoxification unit.

**Hon. Mr. Timbrell:** Again, Mr. Chairman, with respect we're not talking about, we weren't talking about and Mr. Jappy wasn't talking about the detoxification unit going in the hospital.

**Mr. Lawlor:** It would be related directly to the hospital.

**Hon. Mr. Timbrell:** We'll have that hospital's back-up, that's right. But it won't be actually at—

**Mr. Lawlor:** Where will it be?

**Mr. Jappy:** It obviously has to be located in the Lakeshore area to do any good, because the one that was proposed before was up in northern Etobicoke, and that's not where the need is required.

**Mr. McClellan:** So you don't have any—yes, I just read the—

**Mr. Lawlor:** So we don't even know where the hell the thing is going to be.

**Hon. Mr. Timbrell:** It's going to stay where it is, first of all, until such time as St. Joseph's agrees and, second, until the alternative location is found.

**Mr. Lawlor:** Well, all right. So it'll stay where it is, as far as I can see, like most of the other things that have happened in the last few weeks. On the child care unit, you spoke earlier with respect to proper arrangements and ComSoc. You're perfectly cognizant of the letter that was placed in our hands by the Humber Bay Child and Family Clinic on May 31, as to their peculiar problems, financially and otherwise? And that is all.

**Mr. Jappy:** Yes, we had a subsequent meeting with Judge George Thomson and Community and Social Services. I can't recall reading the letter, but I believe the substance was that there is concern that if they take it over and move it off the grounds there will be a lack of funds for administrative services which are now being supplied by Lakeshore. Comsoc and Health have agreed that if and when that happens, we have the responsibility for providing sufficient funds for these administrative services.

**Mr. Lawlor:** Mr. McMullen, your proposals with respect to the Lakeshore hospital and what might be done, even taking into account the removal of the inpatients, have not fallen on all fours with the ministry. As a matter of fact, there's very much of a deaf ear with respect to your proposals.

If I may refer to a document I have here: "It is my understanding"—this is your understanding—"that the ministry desires the outpatient programs currently located in this

facility to continue uninterrupted and to this end I would recommend the following existing services be continued." Among those existing services to be continued is the social orientation centre for the mentally retarded and the dialysis unit, which the ministry seems to go back and forth upon. I'm the last one to criticize it. I think the proper place for it and with the facility set up is the Lakeshore hospital and I wouldn't want the minister to even nudge towards reversing himself on that.

You say in this particular document: "Grave concerns exist that the philosophy and objectives of the outpatients department which now serves the community is not in conformity with those of Queen Street Mental Health Centre.

"As an example, the unit provides services to clients from Peel and Etobicoke and its organization would be altered by the regional philosophy that exists at the Queen Street Mental Health Centre, which does not provide fully integrated community services and thus discourages referrals from general hospitals and other social agencies, such as LAMP Family Services Association and PAR." Would you care to comment on that?

**Mr. McMullen:** This document was written on request, to outline the shape of the programs which were going to continue to exist at Lakeshore. As you read the document, you can see where I made some basic assumptions indicating the location of these programs in the hospital. In so far as outpatient and community services are concerned, it was my contention that the central outpatient department provided a well-tryed and proven method of dispensing outpatient care. At that particular point in time, it was my understanding that this centralized unit would be fractionalized if it was transferred to Queen Street Mental Health Centre.

**Mr. Lawlor:** That point in time being May 28 of this year. Very recently.

The ministry constantly talks about wishing to have input and consultation, and a listening ear to those who are most vitally affected out there, et cetera. When it flows in and a fairly elaborate document is drawn up with good thought put into it, it's jettisoned.

You say, for instance, "Very recent discussions with the administration of Queen Street mental hospital revealed that they intend submitting their somewhat different considerations in this regard"—you're telling me—"and therefore I wish to present the following alternatives.

"1. All remaining services, that is behavioural therapy, dialysis, vocational recreation programs, occupational therapy, speech ther-

apy, DARE, SOC and ASU, be administered by a local administration." Do you still believe that that is the more proper way to do this thing?

**Mr. McMullen:** I think it still has merit. Perhaps over the weeks I've been persuaded to see that there is also merit in having the direct inpatient back-up to the outpatient programs.

**Mr. Lawlor:** I'd ask the minister to reconsider this and give it some more thought in the light of the moves that he's making in this particular area. Whatever happened, Mr. Minister, to Hamilton? How many patients have we going over to Hamilton the day after tomorrow?

[5:30]

**Hon. Mr. Timbrell:** Four have gone.

**Mr. Lawlor:** Four have gone, yes. How many more?

**Hon. Mr. Timbrell:** None.

**Mr. Lawlor:** Oh, boy, did it ever play a salient role throughout the discussions, whenever you were in trouble. It was the safety valve—

**Hon. Mr. Timbrell:** It still is.

**Mr. Lawlor:** —that you were forever using. I didn't think any would go. How does the holiday schedule at the Queen Street hospital affect this proposed inpatient transfer?

**Mr. Fisher:** It doesn't.

**Mr. Lawlor:** There have been no complaints from the union at all as to disruptions, et cetera, in the holiday schedules?

**Mr. Fisher:** To my knowledge we've met all the terms of the collective agreement and I haven't heard of any complaints.

**Mr. Lawlor:** You haven't heard anything?

**Mr. Fisher:** No.

**Mr. Lawlor:** Mr. Chairman, I've done all I can. Thank you.

**Mr. Chairman:** Are there any further questions of the ministry staff? The committee has heard the views of the ministry staff with respect to the transfer of the inpatients and the preparations attached thereto. What is the committee's wish with respect to the re-referral of this matter to the committee?

There are no further questions, so if the witnesses wish to retire we thank you very much for appearing again before the committee.

**Mr. Conway:** Mr. Chairman, since it was my motion that brought the group here today—and I'm joining with you in thanking them sincerely for coming on such short notice—I might say on behalf of my colleagues that

we do weigh very seriously the evidence of this afternoon and, in particular, these statements about the state of the inpatient group at Lakeshore. In that connection, I would move the committee accept—or re-accept or whatever the proper word is—that report that was referred back to us some days ago as a final report on the Lakeshore matter to the House.

**Mr. Chairman:** You are indicating that the initial report which was submitted to the House by this committee be resubmitted to the House. Is that the intent?

**Mr. Conway:** Yes. I think that is the basis of a consensus that was arrived at. We agreed to have it referred back on the grounds of some further discussion about the inpatient transfers. Certainly not all of our concerns are in any way allayed, but as critic in this connection, I am very concerned about the points that have been raised here again this afternoon by certain of the medical staff in particular. It would, I think, be appropriate to accept again the report that was agreed to some days ago and to refer it back to the House as the final report on the Lakeshore matter.

**Mr. Chairman:** And you've made that a motion?

**Mr. Conway:** I made that a motion.

**Mr. Lawlor:** Mr. Chairman, I have another motion, as you know. I intend to move it today either as an amendment to Mr. Conway's main motion or, if you will accept it as such, as a separate motion. The motion reads: "I move that the standing committee on social development not accept the Ministry of Health's report on the transfer of patients from Lakeshore Psychiatric Hospital because of the manifest inadequacies of the report as a comprehensive plan for the transfer of patients. Therefore I move that the ministry suspend all transfers of patients from Lakeshore Psychiatric Hospital for at least six months or until the Ministry of Health has assured this committee that the network of outpatients' community services is fully in place and functioning, and until such time as the Ministry of Health has submitted to this committee for review a study of the capacity of Queen Street Mental Health Centre and the Lakeshore and Whitby Psychiatric Hospitals to care for inpatients and outpatients, and it is approved."

I don't know which way you want to handle that.

**Mr. Chairman:** In my judgement, Mr. Lawlor, I couldn't really deal with that as a separate matter. I'm prepared to accept it as



an amendment to Mr. Conway's motion and the members could thereafter vote on the amendment to the amendment. Depending on what happens we can carry on from there.

If I deal with it as a separate matter and Mr. Conway's motion passed, then procedurally I would have some difficulty.

**Mr. Conway:** Would it assist you, Mr. Chairman: I think Mr. Lawlor should have the opportunity to have his motion put; which I, with all due respect, would accept as essentially a different matter. I would be delighted to withdraw my motion so that his could come first. We could vote on that and take mine second.

**Mr. Chairman:** That might be very much preferable.

**Mr. Conway:** That's fine. I will stand mine down while his is discussed and voted on.

**Mr. Chairman:** Mr. Conway has suggested that his motion be stood down; Mr. Lawlor has put his motion. The committee has heard the motion. Do members wish me to read it again before I put the question, or is there any discussion on the matter before I put the question?

It should be "to care for inpatients and outpatients as is approved by this committee?"

**Mr. Lawlor:** Just make that, "and is approved by this committee."

**Mr. Chairman:** And is approved by this committee?

**Mr. Lawlor:** Yes.

**Mr. Chairman:** Does the committee wish me to read the motion? Members have a copy before them. Is there any discussion on the motion? Are members ready for the question?

All those in favour of Mr. Lawlor's motion, please signify.

All those opposed.

The motion is lost.

Motion negated.

**Mr. Chairman:** Mr. Conway.

**Mr. Conway:** I would just move that the report that was referred back to this committee for reconsideration be now put—

**Mr. Chairman:** Be resubmitted?

**Mr. Conway:** Be resubmitted as the final report, of the standing social development committee on the Lakeshore reference.

That is the report we hammered out here some days ago. It does contain the various positions and does have appended to it a lengthy statement from the New Democratic Party.

**Mr. Chairman:** Is there any discussion on the motion? Are you ready for the question? Mr. Johnston?

**Mr. R. F. Johnston:** I can't let it go by without a comment, I'm afraid.

After we have just received information here today which seems to have allayed the fears of some individuals, I don't see why there can't be a majority report from the sides that agree on closing this hospital, and why the obvious minority report cannot be filed, which is ours. I don't see that there's any difference at this point between the Conservative and the Liberal view. I don't see why we keep the semblance of a difference in our report. I can't help but say that at this point.

**Mr. Conway:** I appreciate that, Mr. Johnston. I just draw it to your attention that we did, largely at the behest of the member for Lakeshore, work out a basis for such agreement as there was and such dissent as there had to be. While recognizing it's a far from a perfect document, it just strikes me as the basis for an agreement that I think should be referred to the House as the final report.

I accept entirely what you've said, but I think the document we have worked out here does, in effect, provide what essentially you are asking in that connection.

**Mr. Chairman:** Ready for the question?

All those in favour of Mr. Conway's motion, please signify.

All those opposed.

The motion is carried.

Motion agreed to.

**Mr. Chairman:** I should indicate to the committee that we are filing with you the Thames Valley District Health Council report which we talked about when the OMA was here. And also the submission of the Public Service Employees Union from Windsor. We're filing that with the committee as well.

**Mr. O'Neil:** Mr. Chairman, are we also filing for the committee members who didn't get them some of the briefs that were received out of town on Wednesday?

**Mr. Chairman:** Yes, we will try to do that, but it takes some time. We'll do it as quickly as we can. Is there a steering committee meeting tomorrow, Mr. Conway?

**Mr. Conway:** I was going to ask if Mr. Breagh is here, but he's not. He just stepped out. What's on our agenda for the rest of the week?

**Mr. Chairman:** My understanding was that we would try to complete the hospital bed referral matter and, hopefully, this week come in with a report. This is the final week, as you know, of the session before the summer recess.



**Mr. Conway:** Do you anticipate the minister being here tomorrow?

**Mr. Boddington:** That was our impression. It was to be today, then tomorrow and the bed matter would be his final appearance. You have only Tuesday and Wednesday left.

**Mr. Conway:** I certainly would like to have a steering committee meeting tomorrow. Tomorrow is caucus morning for most people. I don't know whether a member of the New Democratic Party could comment. Mr. Kennedy, how about breakfast tomorrow? Is that open to anybody or is that too early?

**Mr. Kennedy:** I intend to have breakfast. It's a question of where.

**Mr. Conway:** We can put it over, I suppose. I personally would like to have the

minister here and I think others would probably like to have him here for some discussion on this.

**Mr. Boddington:** I understand he's planning to be here tomorrow afternoon.

**Mr. Kennedy:** Could the steering committee meet at 9:30 tomorrow morning?

**Mr. Conway:** I think so. I can come.

**Mr. Chairman:** We can confirm that then.

**Mr. Conway:** Unless otherwise directed, the steering committee could meet at 9:30 in the members' reading room?

**Mr. Kennedy:** Right.

**Mr. Conway:** That's fair enough.

The committee adjourned at 5:42 p.m.

### SPEAKERS IN THIS ISSUE

---

Breaugh, M. (Oshawa NDP)

Conway, S. (Renfrew North L)

Gaunt, M.; Chairman (Huron-Bruce L)

Johnston, R. F. (Scarborough West NDP)

Kennedy, R. D. (Mississauga South PC)

Lawlor, P. D. (Lakeshore NDP)

McClellan, R. (Bellwoods NDP)

O'Neil, H. (Quinte L)

Pope, A. (Cochrane South PC)

Timbrell, Hon. D. R.; Minister of Health (Don Mills PC)

**From Queen Street Mental Health Centre:**

Durost, Dr. H. B., Medical Director

Fisher, M. J., Administrator

Latimer, S., Director of Nursing

**From Lakeshore Psychiatric Hospital**

Bond, Dr. J. K., Medical Director

McMullen, J., Acting Administrator

**From the Ministry of Health:**

Boddington, G., Executive Officer, Minister's Office

Dyer, Dr. A. E., Assistant Deputy Minister, Institutional Health Services

Jappy, W. C., Director, Psychiatric Hospitals Branch



No. S-27

# Legislature of Ontario Debates

## Official Report (Hansard)

### Social Development Committee

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Tuesday, June 19, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC



## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

TUESDAY, JUNE 19, 1979

The committee met at 3:50 p.m. in committee room No. 2.

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78

(continued)

**Mr. O'Neil:** Mr. Chairman, before we start into what you have planned for today, I wonder if I could ask a question of the minister and the staff. It's something that came to me after yesterday's meeting. I certainly wouldn't want to find that somebody would be out of a job or displaced mainly because they came before this committee and put forth a point of view that might be contrary to the others. I may be just hitting at the wind on this, but it came to me when I questioned Dr. Bond yesterday and asked him whether he was going to the Queen Street hospital.

**Hon. Mr. Timbrell:** He's going to Whitby.

**Mr. O'Neil:** He's going to Whitby; so he has the position?

**Hon. Mr. Timbrell:** Yes.

**Mr. O'Neil:** He still remains with the staff, and there is no problem there with his future employment whatsoever?

**Hon. Mr. Timbrell:** No.

**Mr. O'Neil:** Has he taken a demotion, or is he still at the same level of salary?

**Hon. Mr. Timbrell:** In terms of salary, benefits and so forth, there would be no change. He's going to be—

**Dr. Dyer:** He's going to be director of research and education. He's the head researcher in the dialysis program, which is moving there. He's the chief of the research program.

**Mr. O'Neil:** Would that be considered a demotion?

**Dr. Dyer:** No. That's part of the research program, of which he'll be the director.

**Hon. Mr. Timbrell:** There is already, of course, a medical director at Whitby; so you wouldn't have two medical directors. He'll be carrying on these other activities. I assure you there's no question about continued employment.

**Mr. McClellan:** I would just like to associate myself with Mr. O'Neil's remarks, Dr.

Bond spoke to the committee in a forthright and open way on the basis of a professional opinion.

I want to assure the minister that at no point during the whole process of examination of the Lakeshore issue has anybody in our party tried to take advantage of Dr. Bond's position of knowledge; our discussions have been confined to the open forum of the committee. I want to put that on the record.

**Hon. Mr. Timbrell:** Even if there were other conversations, public-oath considerations aside, I know, for instance, that the member for the area has known the good doctor for as many years as he's been the member of the area, and I'm sure he's had conversations with him during the time when there were rumours around that the hospital would be closed and since the announcement. As I said to you yesterday, I have the utmost admiration for all four of those gentlemen and that one lady as people of professional and personal integrity. That that gentleman or any others disagreed with me or the ministry is certainly no consideration for future employment prospects.

**Mr. O'Neil:** I would hope too that the minister would appreciate that sometimes it's very difficult for people such as that, whether it's for advancement or anything else, to come up with a view that could be contrary to you or to some of your officials. I would hope that you would respect that, and I certainly would. Sometimes you can get people who are yes-sing. When you get somebody like that, it sometimes helps you out too in your job.

**Hon. Mr. Timbrell:** In a ministry of 12,000 people, I can assure you, on any issue there's bound to be the whole spectrum represented somewhere.

**Mr. Chairman:** Before we commence, I should indicate to the committee that because of the Governor General's dinner tonight I would hope that we could adjourn at 5:30, or perhaps even a little before, if that would be acceptable to the committee. Agreed?

**Mr. Minister,** I believe you have a statement.

**Hon. Mr. Timbrell:** Not a formal statement. I just wanted to review and comment on various themes or issues that have come up

in the representations to the committee and in the committee's travel last week.

The first of them that I wanted to touch on is the question of small hospitals. In the last couple of years, as we've applied the various budget formulas, we have recognized that it's the very small hospitals that have the least amount of flexibility to react when compared to larger community hospitals and certainly the very large hospitals in the large urban areas. As you know, we have in each of the last two years applied larger percentage increases to the base budgets. We have built in this year cushions to protect on the bed allocation formula. Progressively over the last couple of years—particularly in the last, I'd say, six to nine months—we've been coming to grips more and more, with the assistance of the health councils and the individual hospitals, with individual situations. I want to just give a couple of examples.

About six to eight weeks ago, the hospital and the board and administration of the hospital in Palmerston came in and we explored their operation and the size of it and the financial aspects of it. In that particular case what was agreed on was that we would settle—and I don't have the numbers in my mind; I'm giving an example of how we're dealing with these situations—settle on what was a mutually agreed minimum size for that hospital to carry out its obligations for both acute and chronic care in that community and area and indicated that we would ensure that the budget reflected that.

In fact, in that particular case I think we said that we would leave it at the existing budgetary allocation subject to an audited review if they have any deficit at the end of the year. I have 27 and five in my head as the numbers of active and chronic beds, something like that, that that's the size beyond which they will not slip. That's the minimum size to be viable financially and to meet the active and chronic needs in that area.

**Mr. O'Neil:** How many beds?

**Hon. Mr. Timbrell:** I think 27 and five in that particular example. Another example would be about a month ago Mr. Speaker invited me to meet with representatives—

Interjection.

**Hon. Mr. Timbrell:** It was a good meeting.

**Mr. Breaugh:** That's what I heard—very good.

**Hon. Mr. Timbrell:** —with representatives of the five small hospitals in his constituency, at Geraldton, Manitouwadge, Marathon, Nipigon and the McCausland Hospital in Terrace Bay. That was an interesting meet-

ing in several respects. First of all, what was being identified were really two or three issues. First of all, concern about active beds. If I remember correctly, something of the order of 11 or 14 beds had been identified in 1980 as being surplus.

At the same time, on the other side of the ledger—and this wasn't even being mentioned in the briefs being sent to me and in the delegations and in the representations being made that day—there is, even at the minimum level for chronic beds among those five hospitals, a deficit of 27 beds for chronic beds.

[4:00]

The second issue being identified was a concern about raising the level of laboratory and X-ray services to ensure their availability on a 24-hour basis and associated issues, such as right now a lot of lab samples go into Thunder Bay by cab at night and from time to time they're frozen by the time they get there, which, of course, from what little bit I know about these things, means that they're destroyed. The third concern had to do with home care, which I've asked the health council to work with those hospitals on.

Coming back to the first issue, all the attention was being focused in on one side of the question, namely, on the active-treatment beds side. They acknowledged that the occupancy rates of their active beds are quite low, that the planning standard is probably appropriate, but they were not in any of their representations looking at the other side, namely the chronic or the long-term care side.

What was agreed on there was that the five hospitals would, as a subcommittee of the Thunder Bay and District Health Council, function as a planning group to sort out what is the minimum size for each of them to carry out its acute and chronic functions, because I don't think any of them—or maybe only one, Geraldton, I think—have any beds presently set up for chronic care.

So in that community or that set, as it were, of communities the work is under way, just as in Palmerston, to set the minimum size to be financially viable and meet the active needs at four beds per 1,000, and add on the chronic care needs in that area.

Now we have, as was indicated some weeks ago, asked COHRAB—or Committee on Hospital Resource Allocation and Budgets—to look at the small hospital situation. In fact, I think it's been suggested to them by my staff that what they should probably do is set up a subcommittee made up strictly of



people from small hospitals to come up with some ideas to assist them to assist us in formulating budgets for 1980 and beyond.

Also—I think this was mentioned before—we're convening a conference of small hospitals in late September. But, all that aside, at this point work is under way in a number of these small centres to ensure that the viability of these small hospitals is maintained.

I certainly do not envisage any of these hospitals being phased out in the future. What I do see is a need for them, either working together, such as that subgroup on the North Shore, or singly with the ministry through their health council, to ensure that there is a rationalization between active and chronic care, as well as to take part in the broader studies, for instance, on long-term care in a place like Grey-Bruce or Lanark or Leeds and Grenville, where we're looking for reports on nursing home bed needs. That's got to be put into the context of what's happening in the hospitals as well.

I know that a number have felt that there should be a distinction between the urban and the rural hospitals as far as the bed formula is concerned, in addition to or aside from considerations that are already implicit in the application of the bed formula, and I'm thinking, for instance, of the application of the age weighting. That tends to work to the benefit of the smaller centres where people concentrate in their retirement years. Certain centres in the chairman's riding certainly represent that.

I was in Brockville a few weeks ago and that is a community that represents that phenomenon, where they have a much higher level of aged population than the provincial norm, because people will tend to congregate there in their retirement years. The weighting formulas work to the benefit of the small hospitals, and we are anxious to have from the committee we set up with the hospital association, involving the small hospitals, any reasonable suggestions that go beyond what we've already done to ensure that we do maintain the viability of all of the small hospitals, financially and operationally.

**Mr. O'Neil:** You're talking about setting up a committee. In other words, you would have people appointed by these hospitals to sit on that committee.

**Hon. Mr. Timbrell:** Yes. You may remember that last November I asked the Ontario Hospital Association and the Ontario Council of Administrators of Teaching Hospitals to form a troika, as it were, with the ministry

that would look at the principles of hospital budgets. Last year we had gone through various exercises trying to identify alternative budget structures and concluded that we'd be best to involve the hospitals themselves along with us. We indicated to them some time ago that we wanted them to look at the small hospital question. Going further than that, I believe Mr. Bain passed on a suggestion that we should have a subcommittee of just small hospital people.

**Mr. O'Neil:** Has that been formed yet?

**Hon. Mr. Timbrell:** I don't believe the subcommittee has been formed yet.

**Mr. O'Neil:** Have you taken under advisement the OHA's willingness to suggest names?

**Mr. Blundy:** Under what number are you talking about?

**Hon. Mr. Timbrell:** Under 100. That's what we've been using.

**Mr. O'Neil:** What about some of the hospitals? I give as an example the Trenton Memorial Hospital which was before the committee in Ottawa and presented what I thought was an excellent brief and more or less gave the background on a hospital of that size. I know that they are quite anxious to set up a meeting with the minister to discuss their problems. Where will they fit into something like this?

**Hon. Mr. Timbrell:** Their particular case is under review. I think they've submitted their figures. Dr. Dyer will be responding to them. Depending upon whether that satisfies their problem, then I'll be glad to meet with them.

**Mr. O'Neil:** I think they fit into a certain category, in between the real big ones and the real small ones. Both you and Dr. Dyer would be prepared to meet with them at any time?

**Hon. Mr. Timbrell:** Yes. Dr. Dyer will be responding to them in writing. If that doesn't answer their concerns, then we'd be prepared to meet with them. They're under 100 beds, aren't they?

**Mr. O'Neil:** I forget exactly how many.

**Hon. Mr. Timbrell:** I've been through it once, but I can't remember. It seems to me they have about 80 or 90 beds.

**Mr. O'Neil:** No.

**Mr. Conway:** About 150 or 160?

**Hon. Mr. Timbrell:** Trenton has 11,000 people.

**Mr. Bain:** I think it is 127 beds.

**Hon. Mr. Timbrell:** Sorry; I thought it was smaller. At any rate, their particular case is under review.

Moving on from there, I know that a great deal of time has been spent on the question of the bed standards 3.5 and four and so forth. I haven't been able to keep up with all of Hansard, but it's interesting to see that while some have criticized the standard, as many or more, drawn from hospitals, health councils and people external to the ministry and working in the consulting field, have indicated that the standard is a reasonable one, always with the caution, of course, thrown in about the small hospitals.

**Mr. Breagh:** Could you just refresh our memory? Is this a standard or a guideline?

**Hon. Mr. Timbrell:** Mid-planning, standard, guideline. Does it matter what word?

**Mr. Breagh:** How much did you pay those consultants to tell you that?

**Hon. Mr. Timbrell:** I guess the word we use is guideline. They say that always with the caution thrown in, which we acknowledge, about the small hospitals. I understand that the group that went to Ottawa were even told by the administrator from the Civic that they could actually function, and function well, below the planning standard of 3.5, provided that more chronic beds were made available.

**Mr. McClellan:** Yes, provided.

**Mr. Conway:** Yes, if you pay for them.

**Mr. Blundy:** Provided you'll be funding them.

**Hon. Mr. Timbrell:** That goes without saying.

**Mr. Conway:** They fully expect under present conditions, Your Honour, to live with that reality, because they don't hold out much hope that the funding requirements will do anything but drive them below—

**Hon. Mr. Timbrell:** That is the hospital, though, that also pointed out that they saved, I think, \$2 million, with the assistance of—

**Mr. Conway:** One hundred and seven positions lost to attrition.

**Hon. Mr. Timbrell:** But they had, by the use of consultants, been able to identify savings of, I think, \$2 million?

**Mr. Conway:** Yes, \$2 million. We shall be talking about that in some detail shortly.

**Mr. Sweeney:** You're opening Pandora's box.

**Hon. Mr. Timbrell:** Really, you're against economies?

**Mr. Sweeney:** No, I'm just saying to hurry up that issue.

**Hon. Mr. Timbrell:** I think it's an issue that certainly should be discussed. This has also been a subject that you've touched on:

the question of incentives—how to provide incentives in such a way as to ensure that good management skills will be applied so that money is spent in the most appropriate way, including calling in either the OHA team that has been developed with a grant from the ministry or outside, private-sector consultants, or whomever, such as you would in the real estate business, the funeral business, et cetera.

**Mr. Conway:** Those are pretty pointed remarks.

**Hon. Mr. Timbrell:** Well—

**Mr. Van Horne:** Is that a street language or something?

**Mr. Conway:** You don't presume the Minister of Health to say it.

**Mr. McClellan:** It is an odd analogy.

**Mr. Sweeney:** I wish I could make a business example over here, but I can't.

**Mr. Breagh:** You don't have to be in the real estate or funeral business—

**Mr. O'Neil:** I don't care which business you're in—

**Mr. Blundy:** And, of course, this is after they've gone through the minister's service—

**Mr. Sweeney:** At least four by eight, yes, by six.

**Hon. Mr. Timbrell:** One of the things that has to be of serious consideration—looking ahead to next year and beyond—is to ensure first, in the fiscal strategy and the budget strategy, that the incentive is still there where rationalizations exist. I'm thinking of communities where perhaps they haven't yet rationalized obstetrical services, laboratory services, laundry services, dietary services, paediatrics, the sharing of computer time—those kinds of things. The incentives are still there to do those things. I think we would all want to see that kind of momentum maintained.

Second, where there is a need to rationalize services as between active and chronic, where the need for active has been reduced but the need for chronic has increased, is to ensure that there are incentives to continue that process.

Third, in areas where they have already reached or are very close to the guidelines, we want to ensure that they do not have to drop further.

These are all considerations which have to impact on, and are already impacting on, arguments that are being made about the 1980-1981 budgets for hospitals and hospital services.

When I was last here we were commenting on several studies that have indicated



there is a pretty general experience that something of the order of 10 per cent of beds—and in some areas it is even higher than that—that are set up and have been set up for acute care are, in fact, being used on a regular basis for chronic care. When Mr. McCarthy was here from Scarborough General, I think that observation was made; it was certainly made by several other witnesses.

At the same time, as I said earlier, it was even indicated that in Ottawa they could do it less than the standard, provided certain other things were in place.

**Mr. Conway:** You can take those 15 per cent out of the city, with no trouble at all?

**Hon. Mr. Timbrell:** Well, let's not make the mistake of planning just on the basis of one hospital; that within Ottawa, if you're going to plan for the chronic needs of the Ottawa referral population, then let's look at the total system and not with blinders on.

**Mr. Conway:** I couldn't agree more. Get those nonresident factors in line.

**Hon. Mr. Timbrell:** That's going to be a very interesting situation, and one that's totally unpredictable, of course.

**Mr. Conway:** The separation of health.  
[4:15]

**Hon. Mr. Timbrell:** Pardon me. I don't know whether Hansard got that. But with the construction in Quebec, first of all, of the new Gatineau Hospital, which is roughly 400 beds—

**Dr. Dyer:** Four hundred, yes.

**Hon. Mr. Timbrell:** —and the addition to Sacre Coeur in Hull of, I think, 50—what's wrong with my French?

**Mr. Conway:** I said to myself, "He's taking French lessons."

**Hon. Mr. Timbrell:** —50 chronic beds. At this point it's a little hard to predict the impact it's going to have on Ottawa, because we have close to 400 beds on any day of any week of the year being utilized by residents of the province of Quebec. That could have a significant impact, depending upon what services they are going to provide in that new hospital. I am thinking of speciality services, because that tends to be why we get such a concentration in Ottawa. At least, it is my impression; it's due to the specialists there. Depending on the services they provide in that 400-bed hospital in the Gatineau, it could have a serious impact on planning in Ottawa, and it's something that bears watching very closely.

**Mr. O'Neil:** Do we know yet what services they will provide in the hospital?

**Hon. Mr. Timbrell:** Not that I am aware. We've got a representative, if I remember correctly, from the Ottawa-Carleton region, Mr. Warren, who sits on a planning body over in Outaouais for that new hospital.

**Mr. O'Neil:** It seems to me though it would be very important to know what sort of facilities are going in there, because it should affect your future planning.

**Hon. Mr. Timbrell:** The regional council and we, a year and a half ago, began funding a long-term health needs study in Ottawa-Carleton, so that will be factored in. That's why I said Mr. Warren, who is the executive director of the Ottawa-Carleton District Health Council, sits on the planning body for the new hospital in Quebec. That can be factored in, because obviously a 400-bed hospital, depending on the services in it, can have a marked impact on what we are going to need on our side of the river in the years to come.

**Mr. Blundy:** What are your views on beds occupied by people from the state of Michigan in the two Sarnia hospitals?

**Hon. Mr. Timbrell:** They are factored in, as you know. I can't recall the numbers off-hand.

**Mr. Blundy:** It's greatly reduced from what it was, but it's still there.

**Hon. Mr. Timbrell:** Yes. The demand has certainly dropped, hasn't it?

**Mr. Blundy:** Yes, very much.

**Hon. Mr. Timbrell:** This is because of changes in the services on the other side of the border, as I understand it, in Michigan.

**Mr. Blundy:** Correct.

**Hon. Mr. Timbrell:** If I remember correctly, the nonresident allocation is about 104 beds for Metro Toronto.

**Mr. Bain:** Eleven.

**Hon. Mr. Timbrell:** It's 11 in Sarnia?

**Mr. Bain:** Eleven in Sarnia.

**Hon. Mr. Timbrell:** Yes; which is factored into the bed allocation. Do you feel there is a problem there?

**Mr. Blundy:** There used to be a problem, but it is being corrected now. There are not nearly as many in the hospitals now.

**Mr. Chairman:** Perhaps the minister could go through his material and then we can attempt to ask questions.

**Hon. Mr. Timbrell:** I don't mind.

The other thing, of course, is that in the budgetary strategy of the last couple of years we have been aiming to bring in the 3.5 and four guideline over a three-year period. That's why I said I recognize some centres



are already at or near that level. Our budgetary strategy for next year will have to reflect that so they don't fall below that.

As well, a year ago February, I announced the existing planning standards for chronic and extended care would become the minimum and, depending upon local planning studies and upon need identified and verified, that additional chronic and extended care over that standard could be approved.

In a number of areas—and I've only given a couple of examples, the North Shore hospitals and various other centres—they are below the existing minimum standard for chronic-care beds. It's a matter of rationalization in the hospitals to ensure that people are, in fact being treated appropriately. They are there now as chronic patients, but they are not being treated as chronic patients. Therefore, I think they are being treated inappropriately, and they would be better looked after in proper chronic programs or chronic units.

The chronic conversion program is one of various alternatives available. I know a number of members have said we have got to have the alternatives available, but haven't really, with respect, been specific as to what they consider to be alternatives. I would point out that a number of alternatives have been developing over the last number of years at the same time strategy has been aimed at rationalizing in the general hospital field. I am thinking in terms of the fact that we have had an 8,000-bed growth, I think, in nursing homes in the last seven years.

In terms of the growth in outpatient surgery, even in the time I've been minister, it's gone from about the low 20s to—the last figure I saw across the system—about 32 or 33 per cent of surgery being done on an outpatient basis.

**Mr. O'Neil:** How much was the increase in nursing home beds?

**Hon. Mr. Timbrell:** It was 8,000 in seven years.

**Mr. O'Neil:** Additional beds?

**Dr. Dyer:** Yes. Additional beds.

**Mr. O'Neil:** That was prior to the freeze?

**Hon. Mr. Timbrell:** Mostly prior to the freeze.

**Mr. Cooke:** When was the freeze put on?

**Hon. Mr. Timbrell:** The fall of 1975; it was lifted in February 1978, subject to local planning studies. We have a proposal before Management Board now for several areas to add nursing home beds based on local studies. As they come in and they're verified and agreed on, we'll make our submissions.

**Mr. Cooke:** When the overall agreement was signed in Windsor, there was an agreement on a need for, I think, 100 new nursing home beds.

**Hon. Mr. Timbrell:** No. Not as part of the agreement.

**Mr. Cooke:** I know it wasn't part of the agreement, but the district health council, I understand, has recommended that.

**Hon. Mr. Timbrell:** They are taking another look at the nursing home beds because, as I recall, we did not agree with the methodology of the first study.

**Mr. Cooke:** Those are the kinds of alternatives I referred to when you implemented that hospital agreement, which I understand is dead now; that the alternatives like chronic home care and nursing home beds were not put in place.

**Hon. Mr. Timbrell:** In that regard can I read you a letter that has been sent to the editor of your local paper?

**Mr. Cooke:** Yes, I would like to, because I wrote you a letter to get an update on that.

**Hon. Mr. Timbrell:** This is from Dr. T. C. White. I don't know if you know him. He's the chairman of the board of the Salvation Army Grace Hospital in Windsor. It's addressed to Mr. Morgan, whom I don't know; you may. He's the editor of the Windsor Star. Dr. White says:

"As chairman of one of the hospital boards involved, I feel called upon to deny as forcefully as I can three implications contained in your prominently displayed news stories in the local hospital situation in Thursday's edition of the Star.

"First, the major headline 'Hospital Reorganization Screeches to a Halt' cannot be supported by any evidence that has come to my attention. The reorganization is, I believe, proceeding in a normal manner.

"Secondly, there is a suggestion in the article that follows that there is some sort of confrontation going on between the Windsor hospitals and the Ministry of Health on the subject of rationalization. Actually, there are details to be worked out by the ministry which may not be completed in time for a July 1 opening of the rationalized services, as previously announced. If not, a new date will no doubt be announced as soon as possible thereafter. There is nothing to support the statement that the hospital 'refuses' to close down its paediatrics unit until the new program is assured.

"The third is to do with a delay of three years in the implementation of the new program at Grace Hospital, which Mr. Chappell is quoted as suggesting might occur.

Actually, Mr. Chappell informs me that he told your reporter that the new program was one which probably would take three years to get into full operation. The three-year 'delay' is one which is inherent in the nature of the program and is not related directly to funding. Gribben is stated in the second article on the front page to have said that the hospitals in Windsor are engaged in some sort of a 'battle for status.' The fact that two of them were willing to close down major and traditional services for the good of the ministry's overall health program does not support the contention that they are promoting self-interest alone.

"It is regrettable if some readers have been misled by Thursday's articles, and it would seem inevitable that they would be. The purpose of this letter is simply to repair some of the damage."

It's signed by T. C. White, chairman of the board, Salvation Army Grace Hospital.

**Mr. Cooke:** That's one of the reasons I didn't raise it in the House this week. I had talked to the administrators, and I knew they weren't in full agreement with the articles in the paper.

Was there not a plan to have the CT scanner in place this fall? That hasn't even been ordered yet. Of course, in the agreement—

**Hon. Mr. Timbrell:** I don't think there was a date attached.

**Mr. Cooke:** In the agreement, which I think has now been filed with the committee, I think there was an October date attached to the CT scanner in Windsor.

**Hon. Mr. Timbrell:** I don't think it could possibly be, because it takes about a year to get them.

**Mr. Cooke:** It takes nine months, and it hasn't even been ordered yet. There's also the closing of the obstetrical ward and the paediatrics ward, and the opening of the chronic care beds—all those deadlines were July 1, and they will certainly not be attained.

**Hon. Mr. Timbrell:** But in the interim they are maintaining their operations. The details of dollars assigned to various budgets—savings as well as costs—are being worked out between the hospitals and the ministry.

**Mr. Cooke:** What effect will this have on the announcement you're going to make in October, or are supposed to make, about chronic home care?

**Hon. Mr. Timbrell:** At the time the agreement said that would be subject to whether there were sufficient savings to apply to a

chronic home care program; that has still not been determined, and won't be for some time.

**Mr. Cooke:** In the agreement, which I have here in front of me, it says the CT scanner was to be in operation by October 1, 1979. That hasn't even been ordered yet. It takes nine months, according to Mr. Mann from Hotel Dieu, which puts it well into 1980.

**Hon. Mr. Timbrell:** This document, signed by all the hospitals and the minister, was a declaration of intent, obviously subject to working out all the figures.

**Mr. McClellan:** Subject to what your intent is.

**Hon. Mr. Timbrell:** The intent's quite clear, very clear.

**Mr. Cooke:** It's clear that none of the deadlines set in the agreement will be met.

**Hon. Mr. Timbrell:** We're working out all the figures. Maybe Dr. Dyer would like to talk about it; he's been in more meetings, even, than I've been.

**Mr. Cooke:** There were some agreements when I talked to the administrator, that, yes, the hospitals in Windsor are working together, and there was unanimous agreement that the problem is not amongst the hospitals in Windsor. The problem is between the hospitals and the Ministry of Health. The funding that was promised and the commitments that were made, in their opinion, were not coming through. That was made very clear to me by the administrator of the Hotel Dieu and the individual I talked to at Grace Hospital. And the phase-in funding for some of these services are not being recognized; the start-up funding. The ministry doesn't seem to recognize that funding associated with it. Accordingly, the prediction from the people I talked to was that the agreement is not dead yet, but that it is very close to being dead.

**Hon. Mr. Timbrell:** No, contrary to what you would like, it is not and it's not going to be. I've heard of your private remarks about what you're going to do to that agreement.

**Mr. Cooke:** I don't know what you're talking about, Mr. Minister, because there are parts of this agreement that I would really like to see implemented, there's no doubt about it. But I make it very clear that I have real reservations about the closing of some of these beds and the overall reduction in active-treatment beds, because you've done nothing with nursing-home beds. There's no guarantee of chronic home care



and I've seen the backups that we had in our hospitals this year before the beds were closed on April 1, which resulted in a coroner's inquest. I'm really concerned about what's going to happen next winter. So, you shouldn't take the point of view that I disagree with all of this agreement. I think you've got the cart before the horse; that's the problem. The alternatives are not in place.

**Hon. Mr. Timbrell:** I want to point out, as I think I did to you before, that in the rationalization Windsor ends up with something like 20 or 24 fewer beds, after active treatment have been closed and chronic-care reopened or, if you will, rationalized. There's also, as you know, a guarantee to the health council—and they're looking at this—that if they identify chronic and extended care needs beyond that, then that will be added on. That study's already under way.

I would like Dr. Dyer, who has been involved in all the meetings with the health council and various meetings with the hospitals, to comment.

**Dr. Dyer:** In the presentation I gave before the committee, I made the comment that this is not an easy process. It really will take some steering to keep it on the rails. Everybody knows that. But the amount of funds, the \$1.3 million, has been identified, has been set aside and we're trying to work out the details of how that money will be allocated.

The hospitals have been reassured that the money can be added to their budgets as soon as we have the details of programs and the procedures of where they'll be implemented and what their costs will be. To this date, although they're working closely with our teams, the hospitals actually have not worked out the actual cost, for example, of conversion of the active-treatment beds to chronic-care beds. There're some differences even between the two hospitals. The cost of converting for a chronic-care bed is \$19,000 at one hospital and \$23,000 at another hospital. That might be quite understandable, but before we fund them we would like to find out what those differences mean. So everybody's working diligently at it, and it's not easy. It will take some time.

The point is, we have now two alternatives that are in writing, and we'll be having another meeting with them next week. Actually, one alternative that was put to us by the hospitals and the district health council has only one very small item to clarify. The minister's seen that; he's agreed with it and

we're prepared to go with that particular position.

[4:30]

**Hon. Mr. Timbrell:** I hope that nothing I have said in the last four or five months has given the impression that I think this is a simple process. It's not. The fact that two hospitals agreed to give up services that they've had, for all intents and purposes since they opened, in order to concentrate those specialties in Windsor, in obstetrics and paediatrics, and to free up money for the services, that's significant and that took a lot of consideration on the part of the administration and boards of those two hospitals.

**Mr. Cooke:** One of the things I don't understand in this whole process, and it applies to other communities too, is how this type of an agreement could ever come about when the bed utilization study was taking place the day you announced the agreement in Windsor and in Toronto. Maybe it's silly, but it seems very logical to me that before you'd want to convert beds and decide on numbers and ratios you'd want to know how the beds are being used presently. Maybe that's too logical; I don't know.

**Hon. Mr. Timbrell:** I believe that there were two similar studies done before.

**Dr. Dyer:** It was an overall study done by Thorne Riddell that identified duplication of services that could be—

**Mr. Cooke:** There's never been any overall study of rest homes, nursing homes and beds, and it is the purpose of the district health council to plan that; so this was a study that was being done.

**Dr. Dyer:** But that's outside the hospital.

**Hon. Mr. Timbrell:** Yes, but this isn't the be-all and the end-all.

**Mr. Cooke:** They help you in figuring out ratios, I would think.

**Hon. Mr. Timbrell:** Yes. For instance, as I mentioned a few minutes ago, one of the things that everybody agreed and acknowledged at the time was that there may well be a need for more chronic beds even than have already been identified in this rationalization process; that and the need for nursing home beds are two central questions to the work of the council right now, which could result in proposals for and approval for even more chronic and nursing home beds than are there now. No, it's not the end of the planning process.

**Mr. Cooke:** The problem being, though, what happens if you find out you have converted some of the active-treatment beds to



chronic-care beds at \$19,000 a bed and the bed utilization study shows you've done the wrong thing? Then you've spent money and you've converted beds and converted—

**Hon. Mr. Timbrell:** The previous studies, based on which the rationalization proposals were developed, haven't indicated that.

**Mr. Cooke:** But the previous studies, as you've already indicated, did not go into rest homes and nursing homes. We don't know whether those facilities are being mis-used, whether people who should be in chronic care are in nursing homes or whether those in chronic care should be in nursing homes, or whatever. We don't know that information, and it just seems bizarre to me that this bed utilization study was going on the very day you announced this grand plan.

**Dr. Dyer:** I think it should be pointed out that we are not talking about converting active beds to nursing home beds.

**Mr. Cooke:** Oh, I realize that; I said to chronic-care beds.

**Dr. Dyer:** The other studies are to establish the need for extended care facilities and outside-of-hospital facilities; so the patient studies that were done clearly did identify the—

**Mr. Cooke:** Even you agreed with me, when I questioned you on this before, that it would've been helpful to have the bed utilization study ahead of time.

**Dr. Dyer:** Of course, yes.

**Hon. Mr. Timbrell:** But since the planning process isn't going to begin and end in 1979, it's going to be an ongoing thing, depending upon—

**Mr. Cooke:** I don't know how you can plan on the basis of no information.

**Hon. Mr. Timbrell:** With respect, that isn't the case at all.

**Mr. Cooke:** It is the case, the bed utilization—

**Hon. Mr. Timbrell:** With respect, you slight the boards and hospitals in that county. You wouldn't have four board chairmen sitting down and agreeing, based on the authority of their boards, to a declaration of intent without information.

**Mr. Cooke:** I don't underestimate the persuasion of Charlie Clarke in the Ministry of Health when it comes to dollars.

**Hon. Mr. Timbrell:** Oh, listen, my experience is that in dealing with Windsor and Essex county or Timmins or whatever, they are all from Missouri, and you don't coerce anybody into signing that kind of thing—no way.

**Dr. Dyer:** I think it's important to know that in Windsor planning is an ongoing process. It'll probably be ongoing for a number of years yet.

**Mr. Cooke:** I thought the problem in Windsor over the last number of years was there has been no planning, like the rest of the province.

**Dr. Dyer:** It's ongoing now.

**Mr. Cooke:** At least that's what I heard from the ministry people, that there was a real problem in Windsor and there hasn't been planning. Now I hear it's an ongoing thing. I am sure the people in Windsor will be glad to hear that.

**Dr. Dyer:** Yes, it's ongoing in Windsor.

**Hon. Mr. Timbrell:** I think it was Dr. Dyer who made the observation one day that the problem with health care—and I think Wetherill and Bennett and Krasny, and so forth touched on this in their testimony—has been that in the past the operative word for hospital planning in Ontario, in Canada and North America has been competition. Over the last five or six years, with the development of health councils and fiscal and planning strategies to back up the role of the health councils, more and more we're trying to turn the operative word from competition to co-operation.

Windsor is no different from most communities where certain hospitals that shall remain nameless for the moment were able to use various means of getting a leg or two up on the other hospitals in town, not necessarily for things that if you were planning on an area-wide basis, on a co-operative basis, you would assign to them. But under the system as it existed throughout North America and in Ontario until five or six years ago, that's the way it was done. Now, more and more—and it's sure as heck is not perfect yet—it's got to be on the co-operative side, not the competitive side. We can't afford to have hospitals competing with one another.

**Mr. Cooke:** Just let me make one thing clear to the minister: On the agreement—and I think I've made this clear, but for some reasons occasionally he picks and chooses what he'd like to refer to—I support parts of the agreement, and most people in Windsor do.

**Hon. Mr. Timbrell:** I support all of it.

**Mr. Cooke:** The part that I am very upset and concerned about is what will happen next winter when the hospital utilization increases again. We haven't got the alternatives in place and they won't be in place by next winter. As I've said before, I think you've

put the cart before the horse. What's going to happen is, if we think emergency rooms and hallways beds were used last winter, we're going to see them used to a greater extent. I just hope there's not another case like Mr. Turski's or something else that occurs.

I agree that there are some active-treatment beds that can be closed provided the alternatives are put in place. I don't think anyone disagrees with that. But you haven't—especially in urban areas like Windsor—put the alternatives in place. I think it would have been wise for you, in your announcement, to have said: "We are going to start chronic home care in Windsor. We are expanding the number of nursing home beds in the Windsor-Essex area and then a certain number of months down the line we are going to convert them to chronic care."

**Hon. Mr. Timbrell:** I've cautioned on this before—not to put so great an emphasis on chronic home care when you talk about the alternatives, because so many people have it in their minds that they can equate chronic home care with chronic care. You can't.

**Mr. Cooke:** I realize that.

**Hon. Mr. Timbrell:** You can't. In fact, if you've looked at the evaluations that have been done to date, and tabled and distributed by me, they indicate that something on the order of only about three per cent of the people who are on chronic home care actually would have been in an institution except that that type of home care was available. By and large we are picking up a new clientele who are not in hospital now, who are not in nursing homes now, who are not in rest homes now; they're in the community.

**Mr. Cooke:** But would eventually go in a nursing home—

**Hon. Mr. Timbrell:** Maybe.

**Mr. Cooke:** —or chronic care, but this preventive service will prevent that.

**Hon. Mr. Timbrell:** No. Read the evaluations. You cannot equate—and we have to be careful not to fall into that trap. In that community, through the rationalization, there is a difference, as I said before, of 20 or 24 beds. Basically, it's a conversion to chronic care within the city. No matter what level of beds are available in a community, if they're properly managed with admission and discharge committees properly functioning in the hospital, if the hospitals are working together so that if one hospital does have a backlog, the others can relieve them; if there's effective management of the elective lists, then there's no need, as I see it, for any community to get into these kinds of awkward positions.

**Mr. Cooke:** The one thing that I found interesting in the coroner's inquest that I attended, and one area where I must confess that the hospital was a little bit vulnerable but your legal representative didn't push it, was that—

**Hon. Mr. Timbrell:** I don't think we had Stan then, did we?

**Mr. Cooke:** Pardon?

**Hon. Mr. Timbrell:** I don't think we even had Stan then.

**Mr. Cooke:** Yes, you did, because Mr. Freidman—was Freidman his name?

**Hon. Mr. Timbrell:** Yes.

**Mr. Cooke:** He was there and did question witnesses. It doesn't seem to be routine that a hospital, when they cannot take a patient, calls another hospital and sees if there's a bed available. At that particular time of the year, in February, all three of the four hospitals were experiencing, on most evenings, all their beds being in use and hallways being used; so in this particular case it probably wouldn't have provided anything. But later, in talking with some of the hospital officials, they told me, for example, if people at Metropolitan called Hotel Dieu, Hotel Dieu would then insist that this person be treated like a brand-new patient, totally re-examined. Then they would make a decision on whether they would admit him. That seems crazy to me.

**Hon. Mr. Timbrell:** It really comes down to physician judgement. I haven't seen the transcript, but from what I have seen of that inquest, it was a determination that the individual did not need to be admitted. Now that's physician judgement.

**Mr. Cooke:** Yes, but that wasn't the determination according to the emergency doctor. The emergency doctor indicated this was a high—I attended, and you'll be getting the transcript and we'll be getting it.

**Hon. Mr. Timbrell:** Well, Mr. Pope was there when it was discussed in Windsor.

**Mr. Cooke:** No, but I was at the inquest. Mr. Pope wasn't at the inquest.

**Hon. Mr. Timbrell:** But it seems to me it comes back to physician judgement as to whether an individual is retained overnight in a room, in the corridor, or whatever. If that's what's needed, then the person not be sent away.

**Mr. Cooke:** Yes, but I thought our leader made it clear today, and doctors and the expert witness at this coroner's inquest indicated that admission of a possible coronary patient into a hallway or an emergency room



really is quite useless, because the equipment that is needed isn't available.

**Hon. Mr. Timbrell:** But it does come back to the question of how the beds in the hospital—and I don't care whether they're at 3.5, four, 4.5 or five beds per thousand—how the beds are being managed. If you have not got an effective admission and discharge committee, and you are not effectively using peer review to ensure that patients are not being kept in longer than they need be, then I don't care how many beds you've got, you're going to have backlogs. You're going to have problems, no matter how many are there.

**Mr. Chairman:** Mr. Pope, do you have a question?

**Mr. Pope:** A couple of questions. The Ontario Medical Association appeared before this committee. In my mind, perhaps others may disagree, they indicated that as far as they were concerned there has been no communication between you and the OMA on your budget system for the allocation of active treatment beds. You hadn't sought out their advice and hadn't made yourself available to discuss these problems with them; in fact, they had some questions about your system and had an alternative consideration that should be put into the allocation system.

I might add that, after we questioned them for a while, they managed to put on the record that they did meet with you twice a month.

But I'd like to know, what is the state of your communication with the Ontario Medical Association? Have they discussed, even since the time of their appearance before this committee, the problem of nonresident population? Have they discussed the question of average length of stay in the hospitals as other criteria that should be folded into your calculations?

**Hon. Mr. Timbrell:** As you indicated, I with the deputy, the assistant deputy minister and all senior management of the ministry meet with them once a month. The agenda is made up of suggestions from both sides; if we have an item we want to put on, or if they have a beef or a question or an issue, they put items on. In addition to that—I was just asking Dr. Dyer—I think there are about another seven or eight different on-going liaison committees with the medical association from various branches of the ministry, from institutional to health promotion to whatever.

Since they were here, let me think, I've met with the president and the general secretary once. As I recall, there was just some

general discussion about the committee. To be fair, we were meeting on another issue but they did not raise those issues at that time. I would expect that at future liaison meetings—or perhaps even at a special meeting, if that's what they want—if they wanted to discuss budgetary policy, I would expect them to do so.

[4:45]

I may say that I can't recall when, but on several occasions over the last year in discussions with the general secretary of the medical association and—well, I can remember that for certain; I won't say "and" presently, because I'm not absolutely certain of my memory there—I can recall discussing, in general terms, the hospital situation. The point was made, and I encouraged this, that if the medical association thought the quality of health care was being compromised, they should certainly be loud and clear on that. I said I would hope so and that I wouldn't want there to be anything but frank and open discussion on that. But they have not indicated to me such a position.

**Dr. Dyer:** The minister, at the OMA convention, urged all members of the medical profession in the hospitals to participate in hospital budgetary processes, as a matter of fact. And they have. They've been increasingly doing that. I think the message is loud and clear, from the ministry at least, that they should become more and more intimately involved. We think they should, in each hospital, become members of the financial committees and so on. And they don't necessarily do that.

**Hon. Mr. Timbrell:** May I just add to that? My comments to the hospital association have been just as strong, because I think some hospitals have been guilty of one of two things. One is that they are dominated by their medical staff—and that happens; the board gets dominated by the medical staff and they do not operate as independent people. Just as bad, if not worse, is the other extreme where the doctors are completely excluded from any of the decision-making processes associated with the operation of these hospitals. Neither extreme is acceptable, as far as I'm concerned, and at the OHA convention and regional conventions I've constantly been urging them to involve their doctors in the decision-making processes.

If you're going to say to your staff that you're concerned about the volume of lab tests or X-rays they're ordering, or the use of whatever services in the hospital, how can you effectively get that message across



unless they are involved in the decisions and see the dollar signs? In that regard, there's a good article in the most recent issue of *Fortune* magazine about Johns Hopkins Hospital that I commend to you as an example. And that's really the private sector, although they're a nonprofit hospital. They have effectively been involving the doctors in administration and saving considerable amounts of money.

**Mr. Pope:** There was another group. I think it was the vice-president, Debra Cooper Burger, who appeared before us in Windsor and indicated that the Ontario Nurses Association didn't feel they had been consulted at all by the ministry. I'd like to know if that's true or not, and what the—

**Mr. Cooke:** She was referring specifically to the Windsor agreement, if I remember correctly.

**Mr. Pope:** Yes, I'm sorry.

**Hon. Mr. Timbrell:** I'm sorry; I missed who said this and was representing whom.

**Mr. Pope:** She was representing the Ontario Nurses Association. She had reference to a position which they took in 1976, and her specific complaint was—Mr. Cooke is quite right—with respect to any discussions over the Windsor arrangement. I want to know, firstly, what the state of your communication is with the nurses association, whether or not you are consulting them on the broad policy guidelines that you intend to implement and have received some correspondence from them; and secondly, what you do to encourage task force implementation groups, study groups, or district health councils to contact representatives of the Ontario Nurses Association, to make sure they're involved and have an opportunity to make representations to these kinds of organizations.

**Hon. Mr. Timbrell:** I meet regularly, not with the ONA, but with the RNAO, the Registered Nurses Association of Ontario, and with the College of Nurses. I have met with the ONA on request. I've certainly never denied them, but in terms of regular liaison meetings, I do meet with the college and the RNAO. A number of our health councils have active members of the nursing profession as their members and I can think of several—but not off the top of my head—who are active members of health councils. In addition to that, as you know, all of the health councils have got task forces or subcommittees on various subjects, and a great many nurses are involved there as well.

**Mr. Cooke:** But in working out the small agreement in Windsor, the registered nurses association was not consulted.

**Hon. Mr. Timbrell:** Neither was CUPE. We were dealing with the people responsible for those hospitals who ultimately, under the Public Hospitals Act and the Corporations Act had to answer for those hospitals, although I can tell you that throughout the considerations of various stages one question I repeatedly raised was the question of staff, relocation and dislocation. As you know at the time, Mr. Mitchell was still a member of the health council in Essex. He has since retired from the council, but he was there and he is an active member of the Service Employees International Union.

**Mr. Pope:** Would you consider advising these implementation groups, task forces and district health councils of the advisability on a regular basis of contacting the various nurses' associations and organizations and the Service Employees International Union?

**Hon. Mr. Timbrell:** Whether it's a health council or whatever it's called, I would think any group should actively seek the ongoing involvement, even if all the involvement they want is just to be kept informed of the activities, of all health-related bodies, whether it's a nurses' group or a local chapter of the Ontario Chiropractic Association or local academy of medicine, or the local district organization of the OHA. Whoever is involved should have an ongoing liaison with them and call on them when their services can be helpful.

**Mr. Pope:** Will you advise them of that fact from now on?

**Hon. Mr. Timbrell:** They have been advised. I also meet with all of the chairmen and directors of all of the health councils twice a year. Perhaps I should put it on the next agenda and reinforce that again. I have done it in the past.

**Mr. Pope:** I'd appreciate it if you would.

**Mr. O'Neil:** Do you feel too that it would be worthwhile to meet with the ONA so many times a year and perhaps have some sort of a liaison such as you have with the other groups?

**Hon. Mr. Timbrell:** I set aside Wednesday afternoons, after cabinet, for liaison meetings. I now have every Wednesday afternoon of the year booked. I don't know what I am going to do when Christmas comes on Wednesday. There are any number of groups with which I don't have regular liaison meetings, but if they have an issue or a problem, I set up a meeting with them, or my staff does.

I am only one person. A lot of times the assistant deputy minister or the deputy minister or the executive director can resolve the issue. Some members have called me trying to set up meetings for delegations. Mr. Sweeney was in just the other day. It took about four or five weeks to set one up. It wasn't a delay; it was just a simple matter of it not being possible to fit anything more into my schedule.

**Mr. O'Neil:** It's my understanding that the ONA was asked to appear before this committee but it probably didn't have time to prepare a brief or something.

**Clerk of the Committee:** They were asked to appear before the committee, but they felt it was short notice. What they said to me was that they would be here as observers.

**Mr. Pope:** They were at Windsor.

**Mr. Conway:** They were certainly on at Ottawa and made a splendid presentation.

**Mr. Pope:** And at Thunder Bay.

A number of specific complaints were raised on which I think the ministry, quite frankly, owes it to this committee to look into. One of the complainants at Windsor was Mrs. Carter who had some difficulties obtaining admission on the night of April 5, 1979. Do you remember if that was at the Hotel Dieu?

**Mr. Cooke:** I believe it was, yes.

**Mr. Pope:** I am sure that some other members have heard some specific instances. I'd like to have some explanation as to the circumstances surrounding those kinds of problems.

**Hon. Mr. Timbrell:** They are all being followed up. Do you know, for instance, whether she went to the administrator of Hotel Dieu since April 5 and indicated a problem?

**Mr. Pope:** I have no idea. We didn't ask her.

**Hon. Mr. Timbrell:** Last Friday the member for Renfrew North asked me a question about the CT scanner, on which I'd like to add further to my answer. I neglected to point out that there are two scanners in Ottawa, not just one.

**Mr. Cooke:** You asked the question.

**Hon. Mr. Timbrell:** There's a whole-body scanner.

**Mr. Conway:** It took both of your colleagues and the independent member for Cochrane South to supply me with an entirely complete answer.

**Hon. Mr. Timbrell:** They are all being investigated. Let me tell you the procedure. Any complaint that comes to us, or to my

office, we refer to the administrator of the hospital because, again, they are legally responsible to the board, which is legally responsible.

**Mr. Cooke:** When are you going to answer some of my letters of complaints then?

**Hon. Mr. Timbrell:** I have answered most of your letters.

**Mr. Cooke:** You haven't answered a couple of open letters, such as the one about what the people in Windsor are supposed to do with no neurosurgeons in the Ontario Health Insurance Plan; I wrote you about that months ago, and you haven't answered that.

**Hon. Mr. Timbrell:** A year ago, without the CT scanner, you wouldn't have had any neurosurgeons; they'd all be going to Detroit or London. But we'll come back to that.

**Mr. Cooke:** That's not the point.

**Mr. McClellan:** You see, you've got to be persistent around here. You can't allow this kind of thing.

**Mr. Pope:** Yes, I'm sorry.

**Hon. Mr. Timbrell:** Don't let me get into giving you facts; I know that might gum up the works.

**Interjections.**

**Mr. Pope:** I'll defer to everyone else after one last question then.

**Hon. Mr. Timbrell:** I haven't finished answering that one.

**Mr. Pope:** Oh, okay.

**Hon. Mr. Timbrell:** Our procedure is that when a specific complaint comes in, it is referred to the administrator of the hospital to deal directly with the individual. We ask the administrator to provide to me or to the ministry, whoever receives the complaint, a copy of whatever he sends to that individual citizen. As a rule, that straightens most of them out. But each of the complaints that were registered at Windsor, Ottawa, Thunder Bay and Sudbury is being followed up.

I want to finish my answer to the member for Renfrew North inasmuch as—I think this will surprise him—I neglected to point out that there are two—

**Mr. Cooke:** It wasn't a question.

**Hon. Mr. Timbrell:** No, he asked a question last Friday. There are two CT scanners in Ottawa. There is a whole-body scanner at the Civic, which is where the brand-new cancer clinic is, and a head scanner at the General, which will move to the brand-new Health Sciences General Hospital when it opens in 1980. In addition, there's a full-body scanner at Kingston General Hospital.

The other thing I want to emphasize again—and we'll look at any submission they make



about their costs of operating that scanner—is that as a class M hospital they can charge back to other hospitals anywhere in the province which refer patients to them, the cost of those services as an outpatient service.

**Mr. Conway:** Just at the risk of abusing the time of the member for Cochrane South, I'd like to reiterate very briefly—I don't know if anyone else here was there; Ms. Gigantes was there, and Mr. O'Neil was there—that the administrator in a very direct way pointed out that his budgetary allocation was such that he could not serve the referred area outside of Ottawa-Carleton with the present restraints that are going to affect that operation.

**Hon. Mr. Timbrell:** All I am saying is, he should put in a submission.

**Mr. Conway:** He said he has "mounted an appeal to the minister."

**Hon. Mr. Timbrell:** It's not in.

**Mr. Conway:** We shall certainly pursue that with much interest, those of us from the hinterland.

**Hon. Mr. Timbrell:** Listen. We'll look at it—

**Mr. Conway:** You deny me a CT scanner? I shall take—

**Hon. Mr. Timbrell:** You've got your CT scanner. I would be glad to personally put you through it.

Dealing on an individual basis, we can sort out these problems.

**Mr. Breagh:** One of the reasons there are problems with X-rays is there are guys like him who are running the machine.

**Hon. Mr. Timbrell:** Come on, now. That's sighting a lot of people.

**Mr. Breagh:** That's true. I take that back.

**Hon. Mr. Timbrell:** There are three last things I want to deal with, Mr. Chairman. One is the question of incentives. I don't want to bore the committee but, as you know, in January we did introduce for the first time a number of financial incentives to the system. Certainly I would envisage coming out of the work of this COHRAB, the Committee on Health Resources and Budgeting, proposals for additional incentives that would assist the hospitals.

**Mr. O'Neil:** Mr. Minister, while you are dealing with incentives, one thing you certainly have to consider is that you are giving incentives to those people who are cutting back their budgets or saving money. When you are looking at the incentive program, go back over the last three or four years and look at some of the hospitals—and again I mention Trenton—that have cut back on their

costs and really trimmed things, and have made, I would say, huge savings. This has meant that the ministry hasn't had to put out additional funds, and yet you bring in an incentive program now. Sometimes these people are forgotten. I just hope that when you and Dr. Dyer look at the Trenton budget, and the budgets of other hospitals of that size, you will take this into consideration.

[5:00]

**Hon. Mr. Timbrell:** I can assure you we will, but I'm reminded of a hospital that came in to see us last year that was pointing to the fact that in the peer groupings they were showing up in the top quartile, saying; "Now we're really efficient give us X dollars." It turned out that if we gave them X dollars it moved them to the bottom quartile of the peer groupings, so I mean you've got to be careful on how you use those kinds of—

**Mr. O'Neil:** Of course that wasn't Trenton.

**Mr. Cooke:** Mr. Chairman, before the minister goes on, because I would like to leave, I would just like to ask a couple of things about the documents that I asked the committee to table. There are two other documents that apparently the minister—I filed two with the clerk, I requested five, but the decision of the coroner's inquest in Windsor, that decision is available. You waved it in front of us in the House when I asked a question on it the Monday after the inquest.

**Hon. Mr. Timbrell:** The two-page thing?

**Mr. Cooke:** Yes. There's that document. I have asked for the transcript too, but I understand that will take a while. Then there was the other document which I believe—

**Hon. Mr. Timbrell:** We'll charge you for it though. We're going to have to pay for it, so you'll have to pay for it through your caucus.

**Mr. Cooke:** No, this committee can pay for it. There was one other document that I asked for, the coroner's jury decision and the hospital agreement which is now there, and the reasons for decision and the affidavits from the Metropolitan General Hospital.

**Hon. Mr. Timbrell:** Get them from them.

**Mr. Cooke:** I will get them from them, but the problem is I cannot get them for Wednesday and your legal staff, I'm sure, have a copy of the affidavits and I'm just simply asking you to table them with the committee. We did not have any hospital boards in front of us in Windsor and that type of information I think is important for us to have, since



Windsor has been a very important part of this whole discussion.

**Hon. Mr. Timbrell:** Obviously, though, you're not going to argue the Supreme Court case here, are you?

**Mr. Cooke:** No. The minister always accepts the decisions or the recommendations of professionals, and these affidavits from professionals, people who are in the know, are important for the committee to have. I would like both those documents the ministry has.

**Hon. Mr. Timbrell:** I'm not sure whether we've got them. It's not our lawyers in our ministry who are taking the case.

**Mr. Cooke:** Well, Mr. Freedman was the lawyer at that case.

**Hon. Mr. Timbrell:** At the inquest.

**Mr. Cooke:** He was at the inquest and he was also at the Metropolitan case.

**Dr. Dyer:** I think it's a different person.

**Mr. Cooke:** A different Freedman?

**Dr. Dyer:** I think it's a Freeman. It's not Freedman.

**Mr. Cooke:** Some place in the bureaucracy over there they have the affidavits and I would like them to be tabled.

**Hon. Mr. Timbrell:** We'll see if we can get them for you, because we're a client of the Ministry of the Attorney General.

**Mr. Conway:** You're not sending Roy to plead your case, I hope?

**Hon. Mr. Timbrell:** No.

**Mr. Cooke:** These documents are not confidential, but they would be helpful. The affidavits are not confidential. They are available, so all I'm asking is that rather than me fly to Windsor and get them you table them with the bloody committee.

**Hon. Mr. Timbrell:** If we have them we'll get them for you tomorrow.

**Mr. Pope:** Could you at this point in time file them as proof of the truth of any situation?

**Hon. Mr. Timbrell:** Not until the matter has been disposed of in the courts.

Mr. Chairman, I don't want to take much longer, but one thing that concerns me, it's come out before in one of the resolutions from the last annual meeting of the hospital association, and it was suggested I think by the OMA when they appeared before you, and that's this question of some kind of an appeal body on budgets which is external to the Ministry of Health. I have to suggest to you, and I know several of you are scholars of Parliament and government, that there is

no precedent. Indeed, there is everything to argue against such a body under our system of government.

**Mr. Breaugh:** What about the Workmen's Compensation Board, disability pensions, grievances, arbitration? You can almost accept that as a little precedent.

**Hon. Mr. Timbrell:** That is quite a different matter, when you're talking about individual benefits, especially under the WCB, which is funded external to government. That's quite a different thing from ongoing funding of programs. I want to suggest to you that no external body should be in a position to order the Legislature and the executive branch to spend money or to raise taxes, which really have to go hand in hand. If any of you are countenancing that kind of suggestion, I would hope you would consider it seriously. There's also the fact that it—

**Mr. Conway:** The accusative case here.

**Mr. McClellan:** Are you rejecting the notion of an appeal mechanism? Is that what you're saying?

**Hon. Mr. Timbrell:** Pardon?

**Mr. McClellan:** Are you rejecting the notion of an appeal mechanism?

**Hon. Mr. Timbrell:** No, I was just going to point out that we have within the Ministry of Health a senior appeals committee which functions every year—it's functioning now—reviewing problem cases. We go through the process from the senior appeals committee to the deputy and up to the minister. Most years we're able to resolve most of the problems.

I just say to you as a colleague, putting aside my position as a minister, as a fellow—

**Mr. Breaugh:** Being totally non-political.

**Hon. Mr. Timbrell:** —being totally non-political, as usual—

**Mr. Breaugh:** That's what I thought. Please tell us when you're doing that, because it's tough to discern it from the outside.

**Mr. Conway:** You'll never shed the great burden of—

Interjection.

**Mr. O'Neil:** I wouldn't mind if anything came to my riding.

**Hon. Mr. Timbrell:** I've been good to your riding. You've got a new nuclear medicine unit at the Belleville General Hospital.

**Mr. O'Neil:** Right.

**Hon. Mr. Timbrell:** I'm speaking to you now more as a fellow legislator. The notion that somebody external to Parliament is going to, in effect, tell Parliament how to arrange its estimates—and with that, of

course, has to go, in effect, the order to either tax or borrow—is totally contrary to all the principles of parliamentary government.

**Mr. Conway:** You and Arthur Maloney must have had an interesting difference of opinion.

**Mr. Breagh:** In your mind it would have to be within the Parliament?

**Hon. Mr. Timbrell:** It would have to be, I would suggest to you, within the ministry.

**Mr. Breagh:** Like this committee, eh? Having to do estimates, I believe, is a very long-standing parliamentary tradition.

**Hon. Mr. Timbrell:** Yes, but even there a committee cannot report back and increase an appropriation. You can comment on the expenditure of the appropriation. You can comment any way you like, but again, under the principles of our more than a thousand year old system of parliamentary government—

**Mr. Breagh:** Thirty-five years—don't go on with these thousands of years.

Interjection.

**Mr. Conway:** I shudder at people who talk about things that have lasted for a thousand years.

**Hon. Mr. Timbrell:** I've checked and Simon de Montfort was a Liberal.

**Mr. Conway:** Joe Clark's going to take him off the corn flakes box, too.

**Hon. Mr. Timbrell:** One last thing I think is important to put on the record. I get more than a little concerned at the notion, sometimes promoted in certain quarters, that during a period of restraint and constraint that somehow the health-care system is shrinking and retreating. I want to read into the record the major and minor capital projects, for the last three years including this current fiscal year.

Interjection.

**Hon. Mr. Timbrell:** That's interesting. We'll come back to that. That's an interesting version.

At North York General, renovations for an expanded intensive-care coronary-care unit.

**Mr. Pope:** This gets into my next question.

**Hon. Mr. Timbrell:** I haven't got—I can get you dollar figures.

**Mr. Breagh:** Stop feeding him material.

**Hon. Mr. Timbrell:** At the Haldimand hospital in Dunnville, renovations for expansion of emergency and lab services.

At the Owen Sound General and Marine, this is the first phase of the amalgamation

between Owen Sound General and Marine Hospital and the Doctor MacKinnon Phillips Hospital. At Sarnia General, renovations for the cardiac unit which the honourable member for Sarnia and I opened just six weeks or so ago. At Sarnia General renovations for the—let's see—the operating room—

**Dr. Dyer:** Recovery, post-anaesthetic recovery.

**Hon. Mr. Timbrell:** —and the recovery room. In Sudbury, the new Red Cross blood transfusion centre, which was just recently completed. At Timiskaming, the new hospital which will open later this year, I guess. A brand new hospital, a replacement facility for two out-dated facilities. At Sarnia, St. Joseph's, an up-grading of support services.

**Mr. O'Neil:** Great member there.

**Hon. Mr. Timbrell:** At the Belleville General, the nuclear medicine unit, which has recently been opened by my parliamentary assistant. I think you were there as well that day.

At Dryden, work under way for the ambulatory care, as well as for fire safety. In Hawkesbury we're working with the local people, as the member for Prescott and Russell (Mr. Belanger) knows, to try to get the project under way for a brand new hospital there.

**Mr. Conway:** We could see it coming anyway.

**Hon. Mr. Timbrell:** Fine, thank you.

In Orillia, at the Soldiers Memorial Hospital, they are working on a replacement for a new wing, which is phase one of their redevelopment. In Terrace Bay, a brand new hospital is planned to replace the McCausland Hospital. In Windsor, there is a rationalization project.

I was just in Fergus a couple of weeks ago and there is expansion of services for outpatient care in Fergus. There is an addition to the Mississauga Hospital as well. I'm not sure if this is on the list but we've given approval to go ahead with planning for a second hospital in Mississauga to be known as the Credit Valley, which is perhaps an appropriate name.

**Mr. Conway:** Wait, now, did you guys hear that? I hope they did.

**Hon. Mr. Timbrell:** No, it's a comment on the cost of health care.

**Mr. Conway:** Timbrell says it's appropriately entitled Credit Valley.

**Hon. Mr. Timbrell:** It's all right. I made the observation when I was at their first meeting, so it's all right.

In Ottawa, there will be a brand new regional rehabilitation hospital, the first footings for which I poured two weeks ago Friday and managed to miss my foot. At Sunnybrook Hospital in Toronto, planning is under way for a new cancer clinic. At the York Central Hospital in Richmond Hill, they are in phase three of their renovations.

**Mr. Conway:** You make John Robarts sound like a piker.

**Hon. Mr. Timbrell:** Her Honour the Lieutenant Governor and I were at the Salvation Army Grace Hospital just last week, along with the commissioner and senior officers of the Salvation Army, to commemorate its conversion to chronic care and also the construction of our very first palliative care unit in Ontario.

In Toronto, at St. Joseph's, there is a change in their intensive-care and coronary-care unit. At the Victoria Hospital in Renfrew, work is under way for the chronic rationalization.

Applause.

**Hon. Mr. Timbrell:** It's not in the member for Quinte's riding.

**Mr. O'Neil:** I take that back.

**Hon. Mr. Timbrell:** At the Tillsonburg District Memorial Hospital phase one of the expansion for outpatients' services is under way. At North York Branson, a \$7 million project is under way for expansion of outpatients' services and support services. In Southampton, there's a program at the Saugeen Memorial for ambulatory care. You already know about that. At St. Joseph's in Sarnia there's a project under way for the condensate, the medical gas lines, to improve that.

At St. Mary's in Timmins, there are improved services for the chronic and the psychiatry, as well as the—I'm not sure this is on the list—the work that is under way for chronic care at the Porcupine General Hospital.

**Mr. Breaugh:** You are running up quite a tab on ribbons to cut.

**Hon. Mr. Timbrell:** There's a major expansion under way at Peel Memorial Hospital in Brampton. At Kincardine, there is expansion for ambulatory care. At the Sensenbrenner Hospital in Kapuskasing, expansion is under way, planned for 1980-81 for ambulatory care.

**Mr. Conway:** The list goes on.

**Hon. Mr. Timbrell:** In Owen Sound, there is the amalgamation. In Sault Ste. Marie at the Plummer Memorial, there is a new psychiatry unit. At the General Hospital in Sault Ste. Marie the new obstetrics unit will give

effect to the amalgamation of obstetrics there. At the Windsor Metropolitan General Hospital, there is the new cancer clinic. In London, at St. Mary's, there is work for fire safety. At the North Bay hospitals, planning is under way for the amalgamations being brought about by those two hospitals. I think they appeared before whichever of you were in Sudbury and told you about the great work they are doing.

At the Ottawa General, there's a brand new Ottawa General—actually it's an expanded name, the Ottawa Health Sciences General Hospital—under construction. It will be finished, I believe, in 1980. Once it is opened and the patients are moved, then the old Ottawa General has been approved for conversion to a chronic hospital with an eventual capacity of 200 patients. Then there's the new dietary—that's not the right name for it, but most of the hospitals in Ottawa got together to agree on a new commissary for dietary services. Eventually in the early 1980s we'll be looking at and planning—some preliminary planning's been done—a new replacement hospital in Owen Sound.

Within the next month or two we should have a report from the Hospital Council of Metropolitan Toronto on the Scarborough situation which will indicate when the last three floors of the Scarborough Centenary should be completed and with what services; active acute care, chronic, or rehabilitation and so forth. Also, I'll answer the question of what we should be planning for the new Grace Hospital in Scarborough.

**Mr. Breaugh:** How about Ajax? George is in a little trouble out there.

[5:15]

**Hon. Mr. Timbrell:** No, as a matter of fact, he's not.

**Mr. Conway:** What have you done for Sydenham?

Interjections.

**Mr. Chairman:** Order, please.

**Hon. Mr. Timbrell:** I think what I'll do, because I don't want to take up too much time—

**Mr. Breaugh:** Let the record show you ran out of gas at 5:15 p.m.

**Hon. Mr. Timbrell:** —I would like to file this with the committee and you can read over the rest of the projects which are under way. Many of them are minor projects, perhaps, compared to some of the major things that I have already mentioned. But they are certainly important to these individual hospitals—things like work on medical gas lines, fire safety, energy conservation, conversions



of beds from active to chronic to take account of their needs in that area, replacing roofs. The point is that a great deal of activity is under way, where needs are identified, to meet those needs and—

**Mr. McClellan:** Do you have any HSOs on the list?

**Hon. Mr. Timbrell:** No, we don't cover, as you know, capital costs and HSOs in as much as they are generally in rented facilities and that would be covered in their budgets.

**Mr. Pope:** I have one last question if I could, Mr. Chairman.

**Mr. Chairman:** Yes, okay, Mr. Pope, and Mr. Sweeney has some questions as well. We will try and finish off at 5:30 if we can.

**Mr. Pope:** Mr. Minister, we've had some discussion in this committee concerning the smaller hospitals. I'm aware of your statement to this committee about a conference on small hospitals in the fall. I just have to voice my concern. It's not that everyone in your ministry is a chiseller but—that's an inside joke.

**Hon. Mr. Timbrell:** I missed that one.

Interjections.

**Mr. Breaugh:** He said not everybody in your ministry is a chiseller.

**Hon. Mr. Timbrell:** Oh, that's fair.

**Mr. Pope:** What I wanted to deal with was some of the concerns I have concerning where we're going in smaller hospitals, particularly, in northern Ontario. This is in the context of what I consider to be a disturbing presentation by an organization called the EHE, a firm of consultants who appeared to indicate the future for small hospitals lies with paramedical personnel and nursing staff giving essential care to the people in the area surrounding these smaller hospitals.

I completely disagree with that in the context of what I see happening with medical schools, with residency requirements for specialization among doctors, and with the increasing costs of modern equipment for diagnostic purposes and therefore their centralization in the major population centres—Ottawa, Kingston, Toronto, London, Windsor. I also disagree in the context of what I, in my own paranoia, see as a trend towards centralization in the larger centres of not only equipment but medical personnel—not even highly trained medical personnel, but adequately trained medical personnel.

May I urge some sort of commitment, or at least understanding, on the part of the ministry of the very real and growing concerns of the people in those smaller centres

as to what the future holds for them in terms of adequate health care?

**Hon. Mr. Timbrell:** I couldn't agree more. I had a very good, although hurried, visit to Kapuskasing last Thursday afternoon—early evening; I want you to know that Mr. Brunelle and I got back at—

**Mr. Conway:** One of these days, and I'm half-serious when I say this, I would really like to see your itinerary for this session. On the one hand, I really respect your commitment to get to every bloody corner of this province, but I shudder to think at the amount of travelling you have done at a point when the ministry in the House seems to have really undergone a measure of debate for which I think you might more properly have been along. It's a judgement call.

**Hon. Mr. Timbrell:** It's a matter of trying to meet people's needs as well.

**Mr. Conway:** Certainly you have done a lot of travelling, and that's all very commendable.

**Hon. Mr. Timbrell:** That's true of any minister; I think we have to just keep in touch. The planning group does the work, but—

**Mr. Pope:** Before you answer, I might say I want to thank the ministry for the consideration it has given to the city of Timmins resolution. I know it took six months, but I do appreciate the efforts that were made. The individual whom I'm talking about as a chiseller really isn't, but it's a long-standing joke.

**Hon. Mr. Timbrell:** The point they were making is very valid. Where they've been able to attract people with certain specialties, obviously they want to keep those people there because, without them, there's an added pressure on regional centres like Timmins, Sudbury, Thunder Bay and Sault Ste. Marie. In addition, there are certain other specialties we would like to attract to the regional centres and beyond the regional centres to places like Kapuskasing and other areas.

I've indicated to this committee and elsewhere that I'm prepared to use the underserved area program, or at least the concept of additional grants and incentives, to get specialties into certain areas. We've already used it for psychiatrists, as you know, for the Cochrane area. This was what I was saying earlier. I guess maybe you had not arrived then. I gave some examples, such as the North Shore hospitals, Palmerston, Penetanguishene and so forth, where we are dealing with them in such a way that the goal is to ensure that they are not left with

just financially viable operations, although that's obviously important, but also operations that are viable in terms of meeting what are actually acute- and chronic-care needs.

That has been one thing that has concerned me throughout this exercise. I'll take my share of the blame, as far as communicating policy from the ministry is concerned, that so much attention has focused entirely on the active-treatment bed side and so little on the chronic-care side. When I could go into a meeting with the North Shore hospitals, where all their submissions, briefs and letters prior to that dealt with questions of active-bed needs and no mention was made of the fact that there was a 27-bed deficit in chronic care, which far exceeds any surplus of identified active beds, that tells us something. We haven't done our job well enough in communicating, but I think there's also a question of the attitudes we're dealing with in planning for hospital services.

**Mr. Sweeney:** You started on at least three occasions to discuss the topic of incentives. Just how far are you prepared to go with them—100 per cent or what?

**Hon. Mr. Timbrell:** Incentives for what?

**Mr. Sweeney:** If a hospital is able to save certain sums of money from its own resources to begin programs that it otherwise couldn't afford, is it going to be able to keep 100 per cent of what it saves or is it going to be cut back? We had a number of submissions before us, saying there really isn't any incentive, or at least they perceived there wasn't any incentive; that what they saved got gobbled up somewhere else. What is your policy? What are you planning to do? Where are you at?

**Hon. Mr. Timbrell:** The policy is automatically to set aside 50 per cent of the savings for new programs or other uses, subject to review and favourable comment by the local health council. The other 50 per cent is theoretically available to the ministry to reallocate as well. When we went to Management Board with our incentives policy, they set that 50 per cent. That's in addition to. Don't forget the other aspects. If they borrow money for cost-saving ventures, 100 per cent of the cost repayment can be borne out of savings. Unanticipated deficits can be rolled over and taken out of savings.

**Dr. Dyer:** At 100 per cent.

**Mr. Conway:** Management Board established the 50 per cent factor?

**Hon. Mr. Timbrell:** In discussions with them.

**Mr. Breaugh:** Just so you wouldn't change your mind.

**Mr. Sweeney:** Quite frankly, if a hospital is operating just about where it's supposed to be and if it knows that out of any saving that it generates it's got to give half back to somebody else—to you or Management Board or whoever it is—what's the point? Why should it bother?

**Hon. Mr. Timbrell:** Let me take the other side. Let me play the devil's advocate. You've seen this as a classroom teacher, as a principal and as a director of education. I've seen it as a teacher and as one who has been involved now for 10 years in public office.

**Mr. Conway:** I'm sure I've seen it as a student.

**Mr. Sweeney:** I doubt it. Students were never aware of what was happening.

**Hon. Mr. Timbrell:** Let me just take the other side and say isn't it a sad commentary on the administration of public affairs that you have to provide incentives to save the public's money?

**Mr. Sweeney:** No, not once you've established—if you're going to have an open costing—

**Hon. Mr. Timbrell:** No, hold on. This goes back to the fact that for as long as anybody can remember—

**Mr. Conway:** Does that really surprise you?

**Hon. Mr. Timbrell:** Oh, no. It doesn't surprise me.

**Mr. Sweeney:** It's human nature.

**Hon. Mr. Timbrell:** Okay.

**Mr. Sweeney:** Especially when you fence people in. Let's take for example—

**Hon. Mr. Timbrell:** Oh, come on now. Do you mean to say—because I know I've talked about it in campaign speeches and public speeches—that you've never said to an audience that it's too bad at the end of a fiscal year people are urged to spend their budgets so that they can make their draw for the next year? You've never complained about that? I'll bet there isn't a member of the House who hasn't complained about it.

**Mr. Conway:** It's just the lowly opposition.

**Hon. Mr. Timbrell:** Government members as well. The fact of the matter is we're talking about multimillion-dollar businesses. Hospitals are spending something like \$6 million a day—in fact, more than \$6 million a day—and we have to give to managers within that system incentives as you would within the private sector. I accept that. This is the first set of incentives we have introduced. They are, I think, a good beginning, but they are just that, a beginning, and we've acknowledged that we would like to go further.



We're obviously subject to overall government strategy and have to get Management Board and cabinet approval for any elements of the fiscal strategy, but the COHRAB group, this group made up of the ministry people, the hospital association, and the teaching hospital administrators' group, I would anticipate would come forward with additional suggestions on incentives. In fact, this committee may want to make specific suggestions on incentives.

**Mr. Sweeney:** You know we are.

**Mr. Breagh:** The Ford Motor Company is a model. That kind of incentive would be particularly attractive to hospitals and doctors.

**Hon. Mr. Timbrell:** Except that I'm not sure we would recover our money as quickly as in that case.

**Mr. Breagh:** I think you would.

**Hon. Mr. Timbrell:** You think so?

**Mr. Sweeney:** Okay. Let's take the other side of the same question. If you're going to put in fairly rigid bed ratios, and hospital boards—

**Hon. Mr. Timbrell:** But they're not.

**Mr. McClellan:** They're standards.

**Hon. Mr. Timbrell:** Okay. But by the time you apply weighting factors—

**Mr. Sweeney:** Standards, guidelines, whatever the flip you want to call them—flip, I said.

**Mr. Breagh:** Flip is unparliamentary.

**An hon. member:** Did you hear flip? I didn't hear flip.

**Mr. Sweeney:** Obviously this is what the hospitals know they've got to shoot for. They've got to shoot for a certain bed ratio.

**Hon. Mr. Timbrell:** But the 3.5 and the four, as you know, when you apply the various weighting factors—and this is also an area where I would anticipate suggestions coming from the Committee on Health Resources and Budgeting—not unlike the development of weighting factors for the GLWs in education, that additional factors are going to have to be taken account of. For instance, we now have a significant weighting factor in there for the aged population, but as the ratio of the aged population steps up significantly—and you know that it's going to go from just under nine per cent to over 13 per cent, at least these are the projections, by the end of the century—that I think will probably have to be taken account of.

We are finding in some parts of the province, particularly in the northwest, that certain groups within the population—I'm think-

ing of the native people—have particularly higher needs for hospital care than the general population, particularly for respiratory problems. Those kinds of things will, I think, lead to additional weighting factors which will take account of local circumstances. That's why we have the weighting factors to apply to them. Of course, the very fact that the guideline for the north is one seventh higher than that of the south is in itself a factor to take account of distance, size of communities and so forth.

[5:30]

**Mr. Conway:** And if you are in between? Do you hope for the Parry Sound syndrome?

**Hon. Mr. Timbrell:** If you are in between, Mr. Conway, I anticipate that the kinds of things we were involved in with the Penetanguishenes, the Palmerstons and the North Shore hospitals—

**Mr. Conway:** Do you consider Palmerston as being in between? I don't.

**Hon. Mr. Timbrell:** —will ensure the continued viability of those hospitals.

**Mr. Conway:** That may be. The problem in my area is that we are desperately caught between the north and the south; many of our social institutions in the areas of education and health fall, I suspect, far more under northern criteria than do areas in Nipissing.

**Hon. Mr. Timbrell:** If I remember correctly, there is a chronic-bed deficit in your county, but there certainly isn't a deficit on the active-treatment side. In fact, I'd be surprised, if you went through either of the hospitals in Pembroke, or wherever—

**Mr. Conway:** I am talking in general terms just about the way in which you approach this situation on a regional basis. We are one of those groups or areas that are severely caught. In most of these areas of social policy, where special provisions are made for the north or for the small communities, we tend to be caught very badly in between. I won't belabour the point; I just make it.

**Mr. Sweeney:** I can see the time is flying. Just let me close off that one question. Whatever you'd arrive at whatever your basis is and whatever little bits of flexibility you build in, once you have a hospital board that gets there, are you going to guarantee them the funding so they can stay there?

**Hon. Mr. Timbrell:** Guarantee them the funding for what?

**Mr. Sweeney:** So they can operate whatever that level happens to be. Let's just say, for the sake of discussion at this particular point in time, that we are talking of a hospital somewhere that has been told that 3.5



is its figure; so it gets there. Are they going to be assured that they'll get enough funding to be able to stay there? Or is the level of annual funding going to be such that they are going to be forced to drop even below it?

**Mr. Conway:** Before you answer that, I'd add a supplementary; you can answer my question as well.

I don't think there is anybody here who would argue that if you accept that there are going to be guidelines for active-treatment beds, or really for any others, that it is not unreasonable for the senior government—in this case, the province—to use its fiscal and budgetary influence to force certain things to happen. Clearly that's what you are doing, and that's quite understandable, given the policy.

What Mr. Sweeney is saying—and it's one point that I think many of us have had put to us—is that if you accept that as a responsibility, to use your provincial authority to twist people, by virtue of budget, down to your guideline, do you not as the senior planning and funding agency have a corresponding responsibility to keep people there once they are there?

For example, in last week's testimony in Ottawa we had the evidence presented by certain people—the Civic is the obvious one again; they were simply pointing out that, yes, they did squeeze \$2 million—at what cost, I don't know. But he is making the point—and I am not one to argue against him right here and now as to what his options are—that if he has to do that next year, if he is forced into a situation where he has to live within those sort of budgetary restraints, he has only one choice; that choice will be, as he says, to shut between 35 and 50 beds, which will drive him below the standard.

**Hon. Mr. Timbrell:** I made several observations earlier about factors that have to be taken account of for 1980 and beyond, and one of them is to maintain the viability of any hospital that gets down to that standard. That doesn't mean we won't continue to urge hospitals to rationalize between hospitals where opportunities present themselves. It doesn't mean we won't continue to urge hospitals to avail themselves of the services of the OHA team or outside consultants, because I don't think there has been an organization set up in any realm of activity that can't stand a regular review by somebody external to and objective about that process.

But the answer is yes, once we get to our planning goals, we have to see that they don't fall below them—but always with the caveat that we must maintain the vigil over the expenditure of this money.

**Mr. Sweeney:** Do you appreciate that four per cent won't let them do that? You can't cut them down from wherever they were to the discussion figure we were talking about, 3.5, and then expect them to be able to continue maintaining that at four per cent or four and a half, whatever the figure may be. That's what I'm really trying to get at. It can't cut both ways.

**Hon. Mr. Timbrell:** At this point we've got about half the budgets in for this year and we are dealing with individual problems, where there is evidence which can be substantiated that they would fall below the standards. We've already helped out a number of them.

**Mr. Sweeney:** I hear you indirectly saying—you're whirling around a bit—but at least I hear you indirectly saying that once they reach the point then you're going to guarantee them in some way that they are not forced by the funding mechanisms from your ministry to go below it again? Am I translating correctly?

**Hon. Mr. Timbrell:** We will want to maintain them at that level, but the point I was making was that we will continue to insist on taking advantage of all opportunities. For instance, if there's a possibility to rationalize food services that has been previously ignored, or laundry, or whatever, we want to ensure that that's followed and that they, from time to time, have an external review of their operation that so far has been identifying significant sums of money to apply to the maintenance of those levels of service. The short answer is yes, with that caveat, that the responsibility to manage all that money requires us to require certain things of them.

**Mr. Breagh:** I just would like, before we wrap up this afternoon, to point out that we've been perhaps abnormally quiet on this side this afternoon. I think it should be put on the record that that's simply because—

**Mr. Sweeney:** David took 40 minutes.

**Mr. Breagh:** We don't have much faith any more in either the intention or the ability of anybody in that ministry to answer a question straightforwardly. That's an unfortunate experience for us, but it's one that is shared by many people around this table and I think some other lessons were learned this afternoon.

Could we just get it clear that the steering committee will meet tomorrow at 10:30, that Mr. Ramsay will substitute for Mr. Kennedy, that we will draft a consensus report at that time? That will be put on the table by the chair for discussion and members are then free to amend, delete, submit dissenting opin-

ions, whatever, and that will be the course of tomorrow afternoon's deliberations; is that correct?

**Mr. Chairman:** Yes, I understand that's the course.

**Mr. Breaugh:** That's fine.

**Hon. Mr. Timbrell:** Mr. Chairman, may I ask the honourable member to be specific? I'd be pleased to match any concerns he has with press releases emanating from his party over the last nine months and the facts related to those press releases.

**Mr. Breaugh:** Let me just give you two quick examples. You asked me and you have made a point of not using people's names in debates in the House. I personally have succumbed to that suggestion on your part and on two separate occasions have given the names of people who went through processes and procedures that you had recommended, both dealing with physicians' services—

**Hon. Mr. Timbrell:** You want to know about the lady from April 12 who wanted gynaecological services.

**Mr. Breaugh:** That's right.

**Hon. Mr. Timbrell:** She had an opted-out physician, decided to change, was given names of opted-in gynaecologists at Mount Sinai and, I believe, Wellesley hospitals and one other, as well as the fact that there's a clinic at Toronto General which she could go through and get the services at opted-in rates. The other one I haven't had a report back on yet.

**Mr. Breaugh:** In both instances neither the people involved nor myself, as the member who asked the question, had been informed until today in that kind of an answer as to what the response might have been.

**Hon. Mr. Timbrell:** No, I'm sorry. My advice is that in the first case that lady was in fact informed of those alternatives and then it was up to her. That's where it stood.

**Mr. Breaugh:** That's not my information. The pertinent point from my point of view is that I was the member who asked the question in the House and I have not been given a response as of yet.

**Mr. Conway:** As chairman of the steering committee and not wishing in any way to interrupt this point of privilege debate, could I be informed once again of what it was that was decided for the committee?

**Mr. Breaugh:** I think it's generally agreed that the steering committee will meet at 10:30 in the morning. Mr. Ramsay will substitute for Mr. Kennedy. We will draft the consensus report at that time, and that will be what is put on the table for debate.

**Mr. Kennedy:** That's not quite the way I understand it.

**Mr. Breaugh:** Have you changed it?

**Mr. Kennedy:** It's not a change. Our material won't be ready at that point in time.

**Mr. Breaugh:** But you will be there to participate in the formation of a consensus report.

**Mr. Kennedy:** We'll be there to participate with yours—

**Mr. Breaugh:** That's fine.

**Mr. Kennedy:** —and with Sean's, if Sean's is ready—

**Mr. Conway:** I hope it will be.

**Mr. Kennedy:** —and to go through it. But our members won't have seen ours and, of course, we want them to see it first.

**Mr. Breaugh:** Yes, sure.

**Mr. Kennedy:** I will say, we hope it will be very concise and won't unduly burden any members of the committee to assess it and evaluate it and put it in context and, hopefully, blend it with the other two, or, even better, find that all members of the committee find ours so totally acceptable that away it goes with unanimity.

**Mr. Breaugh:** I think the important point is that the committee is prepared to accept that a draft consensus report will be put on the table tomorrow afternoon, by the chairman, for the discussion of the members of the committee. It will come out of the steering committee, and we will not get ourselves in the same bind as we did with the Lakeshore discussion of everybody submitting their own little pieces of paper. If we can do that, then I'm convinced we will do what we set out to do.

**Mr. Kennedy:** I want to make it clear that I'm not sure the steering committee would be able to do that totally in the morning, but I think we'll get pretty well along.

**Mr. Breaugh:** No, we will have a draft. We'll have a draft and that will be presented tomorrow.

**Mr. Chairman:** That's at 10:30?

**Mr. Breaugh:** Yes.

**Hon. Mr. Timbrell:** I don't think my privilege was fully answered. Certainly, Mr. Breaugh, if you have any other—I thought you had been informed, but those are the facts in that particular case as reported to me. As well, if you have any other specifics, I'd be glad to know them and I'd be glad to, as I said, give you the mittful of press releases coming from the NDP in the last eight to 10 months that have been factually incorrect.

**Mr. Kennedy:** Mike, when you made that remark that there's less than forthright discussion, or words to that effect, were you referring to a specific incident?

**Mr. Breaugh:** I didn't say that, no.

**Mr. Kennedy:** Whatever it was you said—

**Mr. Jones:** He's been very liberal at times, very candid.

**Mr. Kennedy:** —it rankled with me that you said that there wasn't total openness and frankness with the members.

**Mr. Breaugh:** Yes; I didn't say that, but I would agree to that.

**Mr. Kennedy:** Were you referring to other instances, or within this committee?

**Mr. Breaugh:** Let me give you a specific example. Maybe we can end the meeting on this wonderful note. When we arrived in Windsor there was a request put forward by Mr. Cooke, and agreed upon by all members of the committee there, that attempts would be made to gather certain documents.

There was ministry staff there who said yes, they would attempt to get those documents. That's a week ago. We still have not received the documents.

**Hon. Mr. Timbrell:** That was six days ago, and I wasn't aware of it, but they tell me that they are trying to get those documents for you.

**Mr. Breaugh:** They still haven't arrived.

**Mr. Kennedy:** I just want to say, my impression, over these hearings of a month or six weeks—I can't remember now—is that to me the ministry has brought forward information we wanted and has been very frank and open. I think that should be recognized.

**Mr. Breaugh:** We certainly do disagree on that one.

**Mr. Kennedy:** Okay. But that's my impression.

**Mr. Chairman:** May we end on that note?

The committee adjourned at 5:43 p.m.



### SPEAKERS IN THIS ISSUE

---

Blundy, P. (Sarnia L)

Breaugh, M. (Oshawa NDP)

Conway, S. (Renfrew North L)

Cooke, D. (Windsor-Riverside NDP)

Gaunt, M.; Chairman (Huron-Bruce L)

Jones, T. (Mississauga North PC)

Kennedy, R. D. (Mississauga South PC)

McClellan, R. (Bellwoods NDP)

O'Neil, H. (Quinte L)

Pope, A. (Cochrane South PC)

Sweeney, J. (Kitchener-Wilmot L)

Timbrell, Hon. D. R.; Minister of Health (Don Mills PC)

**From the Ministry of Health:**

Bain, J. W. F., Director, Institutional Operations Branch

Dyer, Dr. A. E., Assistant Deputy Minister, Institutional Health Services









No. S-28

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Ministry of Health Annual Report, 1977-78



**Third Session, 31st Parliament**

Wednesday, June 20, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15 per session from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, Ninth Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3; phone (416) 965-2238.

Published by the Legislature of the Province of Ontario.

Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

WEDNESDAY, JUNE 20, 1979

## MINISTRY OF HEALTH ANNUAL REPORT, 1977-78 (concluded)

The committee met at 4:37 p.m.

**Mr. Chairman:** I'd like to call the committee to order. I should indicate that the following substitutions apply: Mr. Sterling is substituting for Mr. Turner, Mr. Hodgson for Mr. Jones, Mr. Eakins for Mr. Sweeney. The rest of the substitutions apply.

The member for Windsor-Riverside (Mr. Cooke) asked for a document in regard to the verdict of the coroner's jury, with respect to an inquiry at the Windsor Hospital. I now have that document, Mr. Cooke. You would wish it filed with committee members I presume. See that that is done.

We do have some documents here; as a matter of fact we have two pages of recommendations that were agreed to by the steering committee. Perhaps, Mr. Conway, you would like to report on the deliberations of the steering committee.

**Mr. Conway:** Thank you very much, Mr. Chairman. First of all my apologies and appreciation to the other members of the committee for their bearing with us. The steering committee did meet this morning to receive the three draft statements of the individual caucuses with respect to their proposed recommendations on the second term of reference for this committee. Each of the individual caucuses did oblige by supplying that information, and the steering committee thought it useful to try to reduce the various proposals in those three individual drafts to one document, which we did.

We regret that it took as long as it did. Unfortunately there were a number of changes that were required. Most of them are now before you in the first two pages. I understand that the clerk will be supplying the final part of this shortly. What you have before you is a draft proposal from the steering committee, comprising an introduction and 10 recommendations which the steering committee felt would be properly dealt with here, section by section, or vote by vote, to determine just what kind of support each of the recommendations enjoys.

Mr. Ramsay and Mr. Breaugh were present, as well as Mr. Kennedy, for all, or a

large part of those discussions. That, I think, is the understanding that we did arrive at.

**Mr. O'Neil:** Are you going to read this into the record, Mr. Chairman, or have somebody read it into the record?

**Mr. Chairman:** I'm in the hands of the committee. I'd be pleased to read it, and deal with them as suggested by Mr. Conway on a point-by-point basis. It's in the hands of the committee, however you wish to proceed. Do Mr. Kennedy, Mr. Breaugh, or Mr. Ramsay have anything further to add to what Mr. Conway has just said? Mr. Breaugh.

**Mr. Breaugh:** Yes, I'd like to reiterate, for the record, that the draft that is before the committee now is every bit a compromise. It does not represent anybody's particular position at any given point in time. The attempt was made to identify those areas where consensus could be reached. There are some places in here where there will be those who want to dissent from the majority opinion and we attempted to provide for that, but simply to provide occasions where a consensus was possible, to let that be formed.

We did not mean to suggest that, in as short a time as we had, we could provide a comprehensive report, either in terms of the number of sitting days that this committee had nor, most assuredly, in the amount of preparation time that it had for getting together a report of any kind. I think it does point out that if committees are to continue to do this kind of work, some independent staff should be assigned to the committee. The clerk of the committee was hard pressed today, and still is at this late hour, to prepare the report. That should not be the case.

None the less, we feel we do have a draft report that's worthy at least of the committee's consideration and that an occasion will be provided for votes on particular recommendations where anyone deems that necessary. In the final analysis if there are those on the committee who wish to offer a dissenting opinion they will be allowed to do so by filing that dissenting opinion with the clerk.

So, while we should proceed with some caution in this regard, it does reflect the consensus of what's possible, if not exactly



allowing the opportunity to present the most desirable, in-depth report, or to reflect any committee member's particular opinion. It's there for the consideration of the members of the committee. I think it reasonable to say that that's the best you're going to get on this kind of notice with this kind of staff. It at least allows the committee to proceed with a report, which we think is important—and I would recommend that, if you don't read it, and I'm not particularly sure that it's relevant to read the thing verbatim because it has been or will be tabled with the committee as the final sheets arrive. When you call the votes, it would suffice to read aloud those motions or specific recommendations that are underlined as it's laid out here.

**Mr. Chairman:** All right. Shall we proceed?

**Mr. Conway:** Before you do, Mr. Chairman, I thought I'd point out again, it is a draft. There are perhaps typographical errors. Right off the bat, on line five there's a blank for the actual number of briefs we've had. We haven't had the opportunity actually to itemize and total the exact number of briefs there. So I hope all members understand that it is going to be subject to cleaning up those minor technical points.

**Mr. Chairman:** Fine. Is it the wish of the committee that the preamble as outlined form part of the report?

Preamble agreed to.

On recommendation 1:

**Mr. Breaugh:** It's agreed.

**Mr. Kennedy:** Mr. Chairman, before "briefs," that number? Can we leave that to the clerk to fill in?

**Mr. Chairman:** Yes, we can leave that for him to fill in. "Alternatives to institutional care must be in place in the community prior to further withdrawal of funds for institutional care."

**Mr. Leluk:** Mr. Chairman, for the record: It's my understanding that there have been no withdrawals of funds for institutional care and I think this wording should be corrected. As a matter of fact, I understand that last year's funding was in the neighbourhood of \$2,069,860,000 for institutional care in this province and this year's funding is \$2,203,000,000. So certainly that's not a withdrawal or a decrease in funding. That's an increased funding, and I think we should correct the record here.

**Mr. Kennedy:** Mr. Chairman, I speak to the same point. There hasn't been a withdrawal of funds for institutional care. In fact, the increase this year over last is some 6.5 per cent—from \$2.067 billion in 1978-79 to

\$2.203 billion in fiscal 1979-80, which represents the increase of 6.5 per cent. So that's not a fact and as such I can't support it in that terminology. I don't know whether we can reword anything that would be mutually acceptable, but certainly we can't accept that because it's not accurate.

Finally, Mr. Chairman, could I just suggest so the members have an understanding, do you propose that we vote on each one of these as we go through?

**Mr. Chairman:** Yes, that was what I'd proposed to do, Mr. Kennedy.

[4:45]

**Mr. Breaugh:** I would just like to point out to the members of the committee, we have gone around this several times today. I think it's the consensus among the steering committee, not unanimous but the consensus of the people there, that this is the wording we can put before the committee. The committee can vote for it or against it, but it is important that a committee report be completed this afternoon. We have had a full day of negotiating words, phrases and what's in and what's out. I think to paraphrase what Mr. Conway said, "this is it." The opportunity is there for you to vote against it, if you disagree with it, but as it now stands and is printed and is in your hot little hands, that's it. This is one of the places where there was not unanimous opinion expressed, but there is consensus expressed.

**Mr. Pope:** I just have one comment under the actual motion itself, which I assume is the underlined portion. The second sentence says, "Community alternatives must be provided before further active-treatment beds are cut." I have some difficulty with that wording. I think the policy has been that conjunctive with a reallocation of hospital budgets with respect to active-treatment beds, chronic-care beds are also dealt with. But it doesn't say that. The wording is different in the two lines of the motion from the wording in that sentence.

**Mr. Cooke:** What is a community facility or community alternative?

**Mr. Pope:** Well, I don't know. That depends, I guess, on your definition of what a community facility is. I always considered chronic-care beds or a chronic-care hospital to be a community facility.

**Mr. Conway:** If I could just speak briefly to that point. I recognize the points that the honourable members are making. Certainly it comes to my mind that there were a number of witnesses who appeared before me, at least, who reminded me that from where they sat, and dealt with the government in

this connection, they understood the policy's direction with respect to the conjunctive aspect. But their practical experience was that they were being forced to reduce their institutional capacity at a time when those alternate facilities were simply not available. That's the point I'm trying to highlight in that first recommendation.

**Mr. Pope:** If you're distinguishing between institutional aspects and community programs, I think you have to be consistent in the wording there. Perhaps that's where you should have the conjunctive element in it. If that was the concern expressed, that it wasn't being done conjunctively, then perhaps those are the words that should be used. I think we had this discussion—was it yesterday, with Dennis?—about what that kind of a bulge in the financing might do. I think you can safely retreat, and rationally retreat, to a conjunctive recommendation. But "prior to" gives some administrative problems.

**Mr. Conway:** We discussed this in the steering committee. My caucus' position on that is that we'd like to err on the side of caution here almost, in making sure that everyone understands that there is an obvious requirement to put those facilities in place before you force hospitals, like the Alexandra Marine and General in Goderich, to do what's being asked of it at the present time.

**Mr. Kennedy:** One more point, Mr. Chairman.

**Mr. Pope:** We don't have the money for it.

**Mr. Kennedy:** The third sentence states "before further active treatments are cut." Actually, we heard the minister say that this really isn't the situation only minimally, but they're transferred to chronic. There's quite a difference. So we're ready for the question; I am.

Recommendation 1 agreed to.

**Mr. Kennedy:** We will file our dissent, Mr. Chairman. Set out the record the way it is.

On recommendation 2:

**Mr. Chairman:** Bed allocations. "To reduce the present arbitrary system of bed allocation, the calculation of the number of beds to be funded be based on a weighted average number of beds, rather than the maximum number of beds in use at any one point in the year."

**Mr. Conway:** That came from, I think, an excellent presentation from the Sudbury and District Hospital Council.

**Mr. Pope:** Tell me what it means.

**Mr. Conway:** Mr. Chairman, if the honorable member wishes, I can obtain for him the specific recommendation in that connec-

tion that we adopted. I would certainly be quite happy to do so. But I'm not prepared, given the time this afternoon, to engage in a specific and lengthy discussion. That's one recommendation that came out of, I thought, an excellent brief.

**Mr. Pope:** It was never given to me. Where are they?

**Mr. Conway:** It came out of the Sudbury testimony.

**Clerk of the Committee:** They're all being copied now.

**Mr. Pope:** They're being copied now. I mean, you want us to adopt a thing that we've never had a chance to read?

**Mr. Conway:** I must say, Mr. Chairman, that all of us weren't able to attend, in the short time available, to the four particular regional meetings. I read the brief of the Sudbury and District Hospital Council. They made, I thought, a very strong case in this connection, one which was repeated by a number of other groups. Certainly my caucus felt that it was something that certainly deserved serious attention.

**Mr. Chairman:** Perhaps just on a point. I read the Sudbury brief. It was explained, Mr. Pope, very well in a very concise and precise paragraph in the brief, and perhaps if I could just put that on the record, that would explain adequately what we're talking about and what is being conveyed in this respect.

**Mr. Hodgson:** Mr. Chairman, I could very well support this recommendation if the word "arbitrary" is taken out, rather than to reduce the present system of bed allocation. If you took the word "arbitrary" out, I could support it, otherwise I can't.

**Mr. Kennedy:** I would endorse that, too. The minister explained that there has been flexibility and adaptation, so the word simply isn't applicable in my opinion, Mr. Chairman. In fact, I would move its deletion.

**Mr. Chairman:** Well, let's deal with one thing at a time. If I can get that Sudbury—

**Mr. Conway:** I think that Mr. Pope does raise a good point. I'd be delighted to read that into the record for his consideration. It was brought to our attention particularly by the people who attended at the Sudbury meeting. Could I just inquire of Mr. Hodgson and Mr. Kennedy as to whether or not by removing the word "arbitrary" that would then make the recommendation more palatable and they could then support it?

**Mr. Kennedy:** Yes, I don't know what it means, but I could support it. I don't know



what weighted averages you're talking about, but they don't worry me too much.

**Mr. Chairman:** Can we stand this recommendation down until we get that and I'll just read it into the record for the information of the members.

On recommendation 3:

**Mr. Chairman:** "The concept of referral population should be modified to accommodate more fully population mixes, especially the large number of elderly people in certain hospital areas."

**Mr. Pope:** It does. It does now. There are the age classifications from 0 to 14, 15 to 44, 45 to 64, 65 and over in obstetrics.

**Mr. Breagh:** Then we are in agreement totally. There's no need for a vote.

Recommendation 3 agreed to.

**Mr. Conway:** Just in that connection, I think it is important to put on the record that there are an awful lot of people in the health care business who feel, and particularly on the basis of the testimony, and that's what a lot of us are being guided by, that the criteria do not adequately compensate for those elderly. However, I won't belabour the point.

**Mr. Breagh:** We've already had a vote on it. Can we now proceed to the next one?

**Mr. Chairman:** Recommendation 4?

**Mr. Pope:** Oh, I see. You don't want me to speak about it, eh? Is that what you're saying?

**Mr. Breagh:** Normally one speaks before a vote is taken.

**Mr. Pope:** You don't want me to reply to what he said. Is that what you're saying?

**Mr. Breagh:** I don't want to listen to you all afternoon. That's what I'm saying.

**Mr. Pope:** Remember that the next time you rattle on.

**Mr. Chairman:** I know it is getting late in the day and one isn't always as pliable on an empty stomach, but perhaps we can move along and deal with these in as orderly a fashion as possible.

On recommendation 4:

**Mr. Chairman:** "Referral population should be calculated on patient days rather than patient separations." Is there anyone who wishes to speak on this?

**Mr. Pope:** Yes. Unless there are some other controls it's going to lead to the hospitals having patients there longer.

**Mr. Chairman:** Are there any other members who wish to speak on this?

All those in favour on this recommendation please signify.

All those opposed.

Recommendation 4 agreed to.

On recommendation 5:

**Mr. Chairman:** "Where more than one hospital is located within a hospital centre, then any proposed bed allocation should be divided amongst those hospitals on the basis of their share of the total referral population."

**Mr. Pope:** I'm opposed to that, Mr. Chairman. It will lead to hopeless conflicts among hospitals within hospital referral centres. It will make settlements, such as we had in Timmins, impossible, and I don't know how you can arbitrarily assess referral populations within hospital districts with any sort of justice. It will make the amalgamation of services absolutely hopeless.

**Mr. Cooke:** It might have avoided the court case in Windsor.

**Mr. Pope:** Oh, let's not start that because there are a lot of other aspects to that case, which you know exist, that will come out in the hearing.

**Mr. Kennedy:** Rather than the way it's written, I would go along with an amendment to the last line where it has "of their share of the total referral population." Change that to "on the basis of recommendations of local health planning agencies." That will put it in the field of the responsible bodies and I think make it a recommendation that would appear to be logical placed with those bodies.

**Mr. Chairman:** Are you making that proposal as an amendment, Mr. Kennedy?

**Mr. Kennedy:** Yes.

**Mr. Chairman:** Mr. Kennedy has moved an amendment to the proposal. Are you ready for the question?

**Mr. Conway:** The consensus earlier in the day was a recommendation which was put by the member, as I recall, for Oshawa. I'm wondering whether or not he would care to comment on that amendment in any way?

**Mr. Breagh:** Sorry, I was engaged in a little byplay.

**Mr. Conway:** As I recall, that particular recommendation was extracted from your position paper. I'm wondering how you react to Mr. Kennedy's amendment?

**Mr. Breagh:** I don't think the amendment is necessary, and I will not support it. Later in the brief we go on at length on being extremely supportive of local planning facilities—whatever they might be; either a district health council or even the ministry itself. I do not think it's necessary and I would not like to see it clutter the issue.

**Mr. McClellan:** Again, if I can say just very briefly, remember this responds to a par-



ticular concern that was identified with respect to the hospitals within Metropolitan Toronto, and speaks to the imbalance of active-treatment beds that results from the large number of nonresident patients that are accommodated in Metropolitan Toronto.

Mr. Kennedy's amendment, as Mr. Breagh said, isn't necessary, because later on we address ourselves to the rectitude of local health planning bodies making these kinds of decisions. What we're trying to set out in this recommendation is a basis for their making those decisions, and if you take the referral population out, then you don't address the issue and you don't deal with the problem as affecting my community and other communities that we heard from during the course of our hearings.

Mr. Kennedy: Mr. Chairman, if somebody makes a decision on this, as I read it, it would be sort of a hospital-by-hospital thing. In the narrative following you mention that it's imperative in Metro Toronto, and there should be some overall agency that does it, and who better than the—

[5:00]

Mr. McClellan: Yes, but this sets out a basis for making that decision. You make it on the basis of the referral population.

Mr. Kennedy: Who makes it?

Mr. McClellan: Whoever makes it. Later on we'll deal with who makes the decision.

Mr. Kennedy: Later on, where?

Mr. Breagh: Which one? We accepted your recommendation about who advises the minister.

Mr. McClellan: This sets out criteria for the decision-making which we're supporting under recommendation 9. It's not inconsistent; we're just trying to set out criteria for the decision-making, which is rightly identified in recommendation 9.

Mr. Hodgson: Mr. Chairman, one of the problems with this recommendation 5 is you don't have hospitals. If you have two hospitals in one community, one hospital may have better treatment facilities or better health equipment than another, and you lump them all the same. You base them all on so much per population; it says here four beds per 1,000 population. In Metropolitan Toronto you have different hospitals with different health equipment, to which a lot of people whom I represent are referred, because we haven't got those kind of health facilities. For you to say it should be shared equally might be a good recommendation, but it could work to the detriment of us all.

Mr. Chairman: Are you ready for the question?

All those in favour of Mr. Kennedy's amendment please signify.

All those opposed.

Motion negatived.

Mr. Chairman: All those in favour of recommendation 5, as proposed, please signify.

All those opposed.

Recommendation 5 agreed to.

On recommendation 6, small hospitals:

Mr. Chairman: "Recognizing that the minister has established a committee on hospital resource allocation and budget, the committee recommends to the minister and the committee on hospital resource allocation and budget that bed allocation guidelines should be applied with sensitivity to the local situation and in consultation with local health planning agencies."

Mr. Pope: That's an interesting juxtaposition. I was just wondering who set up the standard in recommendation 5 and then talked about a guideline in recommendation 6. Interesting.

Mr. R. F. Johnston: That's what you do anyhow, set up the guidelines and then follow them.

Mr. Chairman: Is there any further discussion on this?

All in favour of recommendation 6 please signify.

All those opposed.

Recommendation 6 agreed to.

On recommendation 7:

Mr. Conway: That might be clarified. This is a second recommendation, really, within the category of small hospitals. The 10-bed cushion obviously refers to the 10-bed cushion within the present guideline.

Mr. Chairman: The 10-bed cushion shall continue indefinitely; that's the recommendation. Any discussion?

All those in favour of recommendation 7 please signify.

All those opposed.

Recommendation 7 agreed to.

On recommendation 8, hospital incentives:

Mr. Chairman: "The committee recommends that financial rewards for efficient hospitals should be factored into the budget calculations."

Mr. Breagh: I'd like to move an amendment. I am in agreement with the recommendation itself, but I would like to move that the text be amended to strike the word "completely" and the words "in part," so that the last sentence of the text would read: "Further, we feel savings should not be appropriated by the ministry, but rather

should benefit the hospital and the community it serves."

**Mr. Chairman:** That's the last sentence of the text. Is there any discussion? Mr. Kennedy?

**Mr. Kennedy:** That flies in the face of what is transpiring at the moment. The ministry, the taxpayers generally, have an equity in each hospital. They have an increment, if you like, and as I understand it it's because of this, that if there are economies effected there is a division of such savings. It was quite thoroughly discussed in the committee by witnesses, and we would not endorse the deletion of the word "completely." In other words, a sharing of savings as are set out would continue on some basis or other.

**Mr. Chairman:** Any other comment? Are you ready for the question?

All those in favour of Mr. Breagh's amendment please signify.

All those opposed.

The amendment carries.

All those in favour of recommendation 8, as amended, please signify.

All those opposed.

Recommendation 8, as amended, agreed to.

On recommendation 9:

**Mr. Chairman:** Recommendation 9 reads: "We recommend that this committee endorse the efforts of hospitals, district health councils, and other local health planning agencies to rationalize health services where appropriate by encouraging co-operative planning among hospitals. The committee also supports the use of an independent expert to assist hospitals in examination of their operation."

Any comment? Are you ready for the question?

All those in favour of recommendation 9 please signify.

All those opposed.

Recommendation 9 agreed to.

On recommendation 10:

**Mr. Chairman:** Recommendation 10, hospital appeal mechanism: "A hospital appeal mechanism should be established."

**Mr. Pope:** That would be an independent appeal procedure; I assume the decisions would be binding on the ministry. I assume that is what you're saying, so that there is no misinterpretation.

**Mr. Conway:** I can speak to that. The intent of that recommendation is very attractive to my caucus, because we do feel it is inappropriate, and dysfunctional almost, to be having the courts on so regular a basis do what a more appropriate and public appeal mechanism could accomplish. I'll make no

bones of the fact that as to exactly what kind I'm not sure, but I am sure there should be one. The present mechanism which exists is essentially very private and operated by the very people who operate the funding agency. That's not something we're very pleased with, so for that reason I feel a hospital appeal mechanism, that is a public appeal mechanism, must be established for the purposes of airing many of the grievances that have come to this committee in the recent past.

**Mr. Pope:** I am opposed to this recommendation. That's hardly an appropriate mechanism. There's no accountability, there's no overall control of expenditures by the government which has to be accountable to the people of Ontario for the taxpayers' money it is spending. It's something over which this Legislature would have virtually no control. I don't think it's an appropriate recommendation for any government to undertake, particularly our form of government. The minister made it quite clear yesterday that this kind of a recommendation could not be accepted by the government.

**Mr. Chairman:** Mr. Leluk.

**Mr. Leluk:** Mr. Chairman, I just wanted to voice the same concerns and objections that have been put forward by my colleague, the member for Cochrane South. We already have a senior appeals committee in operation. As the member has pointed out, the government is charged with the responsibility for spending of public funds and for that reason we won't be supporting the recommendation.

**Mr. Conway:** I hope you will vote to appeal the Ombudsman Act as well.

**Mr. Pope:** That's hardly a mechanism; other than its budget, which is submitted to the Legislature which is responsible for the expenditure of massive amounts of public moneys, without any accountability to the people of the province.

**Mr. Breagh:** It has been pointed out by a number of members on the committee, that yes there may be an appeal process but it's totally in-house. We have raised time and time again, the difficulty that this committee has had in ascertaining what the financial problems of any given hospital board are. Access to that information is somewhat limited and there is a reluctance on the part of a number of boards to appear in public and have this kind of a discussion. You may recall that the Ontario Medical Association and the group of doctors who appeared from teaching hospitals here in Toronto differed somewhat on their opinions as to the reason for that. One witness ascribed it to pride: that



hospital boards did not want to admit they were having financial difficulties. Others said they were afraid that by making their case publicly known and being the exception in doing so they would face further reprisals from the ministry which ultimately approves their funds. We feel it is time to operate the appeal mechanism openly, and that it should be done by an independent agency that can make recommendations to the minister.

We are flexible on the technique to be used in setting up the agency. The basic principles are: there are massive amounts of public moneys being spent in hospitals, the public has a right to know the facts of the matter and therefore they should be put before an independent agency; that it is not realistic to expect the Ministry of Health itself to make such arbitrary decisions.

We recognize that appeal agencies are used almost ad nauseam across the province of Ontario. There are some special circumstances that dictate that this one would have to be set up with some care, but we are not prepared to move off the basic point that there ought to be a fully public, independent agency to which both parties can submit their arguments, and that can offer advice to or make final decisions on behalf of the ministry.

The important thing I want to reiterate is there is a lot of money being spent here and there is a need to have an independent agency make that assessment. It is not fair, in our view, to have the ministry in the first instance set the guidelines, in the second instance hear the appeals in private, and in the third instance have final approvals. There is a need to have a degree of openness in the midst of all of this.

**Mr. Kennedy:** Well, Mr. Chairman, this recommendation goes against the principle that the government is responsible for budget and expenditures, and is held accountable. We do have the in-house committee that is an appeal body. I think a fair analogy would be that of a board of education, for instance, which when told of the grants it will receive in a fiscal year would say that isn't enough, we'll go to the independent body. The independent body then tells the government, "Look, give them more money." Where does accountability go? It flies in the face of our system of government and accountability, and as such I couldn't support this mechanism.

**Mr. Pope:** If this is the first in a series of efforts by the opposition parties, because the same reasoning could apply to every other ministry of this government, you would have government expenditure directed by independent commissions and appeal tribunals

without accountability to the people of this province. If that's the rationale for effective government that the opposition parties want to support, so be it.

There has been discussion and inference by the member for Oshawa that there is some form of extortion going on between the Ministry of Health and the hospitals. He has tried to draw it out of various witnesses before this committee with leading questions. He hasn't succeeded. Now he is trying to substitute his opinion as that of the Ontario Medical Association and some witnesses from the teaching hospitals. It doesn't wash. They never made those statements. They never agreed with the leading questions of the member for Oshawa; I don't think there is any basis for making a statement that there will be retaliation if there's an appeal of the budget.

[5:15]

**Mr. Breugh:** I will ignore the interjection and in doing so try to set an example for the Premier (Mr. Davis). We were attempting to do something constructive. It is the practice, a rather widespread practice in the United States for example, for hospital boards and all kinds of boards and agencies which are having difficulty with their funding to seek redress through the courts. We now have a precedent of that in Ontario. We think that's unfortunate and that it should not be the route to go.

As an alternative to that, we are proposing an appeal mechanism which allows for full public disclosure and discussion of the matter. We feel that would be preferable to having hospital boards across Ontario sue the ministry, or go before a court to get some kind of an application to set aside a ministry guideline. We think this is a workable notion. We do not mean to cast aspersions on hospital boards themselves or on the many hard-working people in the ministry, but we are concerned that a mechanism be found to resolve disputes that allows it to be done publicly and openly, so that both sides feel quite free to state their case and let the argument be settled there.

**Mr. Chairman:** Ready for the question?

All those in favour of recommendation 10 please signify.

All those opposed.

Recommendation 10 agreed to.

Interjections.

On recommendation 2:

**Mr. Chairman:** Going back on recommendation 2, I promised Mr. Pope that I would get the applicable section in the brief, which I think rather clearly explains what is



meant by this particular recommendation. This brief was submitted to our group by the Sudbury and District Hospital Council last Wednesday, June 13, in Sudbury. Part of that brief says: "The ministry has used the number of beds staffed in October, 1978 in their calculations, and in most cases this represents a maximum number of beds that would be staffed at any time during the year. However, the average number staffed through the year would be considerably lower.

"For example, at the Sudbury General Hospital in 1978 there were 37 beds closed for 115 days in the summer, and another 37 beds closed for 60 days. As a result, the average number of beds in operation in 1978 was 271, not 288 as calculated by the Ministry of Health. On this basis, there is a shortage of beds in Sudbury for 1979-80, not a one-bed surplus as stated by the Ministry of Health. The calculation must use the weighted average number of beds, not the maximum number of beds at one point in time.

"The savings from temporarily closing 40 beds for three months, for example, is greater than the savings from closing 10 beds for 12 months. So the ministry must not arbitrarily limit the hospitals to the same number of beds in operation throughout the year. The hospitals must be allowed to adjust their beds to meet the clinical fluctuations in patient-days as long as they stay within the ministry's standard on a weighted basis through the year."

Does that convey what—

**Mr. Pope:** That conveys a system of calculating the bed occupancies on the basis of statistics which will be supplied by the hospitals, and with no ability in the ministry to determine whether or not they are accurate.

**Mr. Conway:** That is a subject of local control.

**Mr. R. F. Johnston:** Local autonomy seems to be flying in and out of this matter.

**Mr. Pope:** How would you like it handled? You're talking about local autonomy. How would you like it handled?

**Mr. Conway:** Perhaps we'd like it handled somewhat differently than the situation in which Durham and Chesley found themselves when the regression analyses, which was the statistical body of evidence that was to close those hospitals, proved to be inaccurate or incomplete to say the very least.

**Mr. Pope:** And what happened?

**Mr. Conway:** The charge was made—

**Mr. Pope:** And what happened; just a second, what happened?

**Mr. Conway:** The charge was made, Mr. Chairman, that perhaps the local hospital

authorities would not have the most complete or accurate figures. My limited experience, in a limited period of years in this Legislature, proves to me that is a charge that can sometimes be levied against the senior planning and funding agency at the Ministry of Health.

**Mr. Pope:** What happens when there is a disagreement; what happens?

**Mr. Conway:** The courts have been the place where it's had to be resolved.

**Mr. Pope:** Sure; sure they are.

**Mr. Conway:** That's where that particular episode was resolved.

**Mr. Pope:** Sure they are. All across the province we're having court cases. We have had for years.

**Mr. Conway:** The ministry is giving the hospital sector very little choice.

I want to say, Mr. Chairman, that certainly the steering committee discussed the matter and felt these recommendations were to be understood, as the preamble indicates, on the basis of a reasonably short period of days. Indeed there was perhaps a less than complete survey of all possible witnesses, but we did believe they were sufficiently important. I want to highlight that I certainly would like to discuss with the Minister of Health, during the fall session, his response to what we have recommended here. If there are overwhelming reasons why certain things can't be lived with, then I believe this is the room, this is the forum, this is the mechanism in which there is a possibility and a public dimension where those matters should be dealt with.

**Mr. Pope:** He's already told you why he can't live with your last recommendation, you've chosen to ignore it. Why go through this charade of saying he should come back and discuss it again?

**Mr. Conway:** There are nine other recommendations.

**Mr. O'Neil:** Maybe it's a chance for him to have a look over the decision he's made too; maybe it's not absolutely correct either.

**Mr. Chairman:** Mr. Ramsay?

**Mr. Ramsay:** I would move an amendment to recommendation 2 to reduce the present system of bed allocation, just removing the word, "arbitrary"; I would so move.

**Mr. Chairman:** Are you moving that as an amendment?

**Mr. Ramsay:** Yes.

**Mr. Chairman:** Any discussion? You ready for the amendment?

**Mr. Conway:** We're talking about removing the word "arbitrary" from recommendation 2; okay.

**Mr. Chairman:** Ready for the question?

All in favour of Mr. Ramsay's amendment please signify.

All those opposed.

The amendment is lost.

All those in favour of recommendation 2 please signify.

All those opposed.

The recommendation carries.

Recommendation 2 agreed to.

**Mr. Chairman:** This completes the recommendations. I want to thank the committee for its co-operation. More particularly, I want to thank members of the steering committee for the good work they have done throughout the day.

Further, I want to pay a special tribute to our clerk, Fran Nokes, who has done yeoman service today. I want to say that we greatly appreciate it.

This is our last meeting, to my knowledge, before we break for the summer. I want to wish everyone a good summer and we'll see you in the fall.

**Mr. Kennedy:** I want to reiterate that on some of these, for the reasons given, we will be filing dissents with the chair.

**Mr. Chairman:** I understand, fine.

**Mr. Kennedy:** Do we want to discuss the time allocated for Ministry of Health estimates at this stage?

**Mr. Conway:** About Health estimates and the time allocation for the Health estimates in the committee, it was suggested in the steering committee that my original motion of some months ago now be amended to read "not more than 10," as opposed to not more than five hours, be deducted against Health estimates, which would then practically leave 10 hours of the 20 hours in Health estimates. That was the discussion in the steering committee and that's certainly agreeable to me.

**Mr. Chairman:** So that the allocation of time to the Health estimates will now be reduced further from 15 to 10, is that it?

**Mr. Conway:** The motion actually reads that not more than five hours be deducted from Health estimates for these references. We agreed in the steering committee that be amended to read not more than 10 hours, which leaves us with an agreement to have 10 hours for Health estimates.

**Mr. Chairman:** Right. The practical effect is that we have 10 hours remaining for Health estimates.

**Mr. Conway:** That's a clear understanding, 10 hours remaining for Health estimates.

**Mr. Chairman:** Agreed.

Any further business? Thank you very much.

The committee adjourned at 8:23 p.m.

### SPEAKERS IN THIS ISSUE

---

Breaugh, M. (Oshawa NDP)  
Conway, S. (Renfrew North L)  
Cooke, D. (Windsor-Riverside NDP)  
Gaunt, M., Chairman (Huron-Bruce L)  
Hodgson, W. (York North PC)  
Johnston, R. F. (Scarborough West NDP)  
Kennedy, R. D. (Mississauga South PC)  
Leluk, N. G. (York West PC)  
McClellan, R. (Bellwoods NDP)  
O'Neil, H. (Quinte L)  
Pope, A. (Cochrane South PC)  
Ramsay, R. H. (Sault Ste. Marie PC)





No. S-29

# Legislature of Ontario Debates

## Official Report (Hansard)

### **Social Development Committee**

Estimates, Ministry of Health

**Third Session, 31st Parliament**

Wednesday, October 10, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

### STANDING SOCIAL DEVELOPMENT COMMITTEE

**Chairman:** Gaunt, M. (Huron-Bruce L)  
**Vice-Chairman:** Kerrio, V. (Niagara Falls L)  
Belanger, J. A. (Prescott and Russell PC)  
Blundy, P. (Sarnia L)  
Cooke, D. (Windsor-Riverside NDP)  
Grande, A. (Oakwood NDP)  
Johnston, R. F. (Scarborough West NDP)  
Jones, T. (Mississauga North PC)  
Kennedy, R. D. (Mississauga South PC)  
Leluk, N. G. (York West PC)  
McClellan, R. (Bellwoods NDP)  
O'Neil, H. (Quinte L)  
Ramsay, R. H. (Sault Ste. Marie PC)  
Rowe, R. D. (Northumberland PC)  
Sweeney, J. (Kitchener-Wilmot L)  
Turner, J. (Peterborough PC)

Hansard subscription price is \$15.00 per session, from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, 9th Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3. Phone 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.

# LEGISLATURE OF ONTARIO

WEDNESDAY, OCTOBER 10, 1979

The committee met at 2:20 p.m. in room 228.

## ESTIMATES, MINISTRY OF HEALTH

**Mr. Acting Chairman:** I see a quorum. The Minister of Health.

**Hon. Mr. Timbrell:** Mr. Chairman, first of all, in the spring, since we didn't really do estimates as such, I didn't get a chance to introduce to the committee my new deputy minister, who is now not so new. I guess he is about seven or eight months into the job.

Mr. Campbell, as you know, came to our ministry from the Ministry of Northern Affairs where he was the founding deputy minister. Prior to that, he had served in the cabinet secretariat and, prior to that, in the Ministry of Education and the Civil Service Commission.

**Mr. Conway:** That's almost like going from riches to rags.

**Hon. Mr. Timbrell:** Riches to riches.

**Mr. Conway:** Would that you had the Minister of Northern Affairs' (Mr. Bernier) barrel. I don't mean a physical barrel.

**Hon. Mr. Timbrell:** I thought I might just take some time today to speak, not from a prepared text but from some notes, on trends in the ministry in 1979, now that we are a little more than halfway through the fiscal year which we are discussing.

Needless to say, it has been an interesting year for me as minister and for the ministry and all connected with it. We started out the year with the Anti-Inflation Board controls coming off us as much as anybody else, but of course this is a very large industry, if I can call it that, in Ontario, inasmuch as in the hospitals alone I believe the employment figures for full-time and part-time staff come to something in the order of 125,000 people, which is not that far off the total population of our smallest province of Prince Edward Island.

With the controls coming off, a lot of concerns existed at the time as to what effect this would have on costs and on programming. This came at the same time as we were continuing our efforts to keep our increases in spending under control for the whole

government and every program within the government.

I want to say that I have been very fortunate to have the assistance of people like Mr. Campbell and my assistant deputy ministers and all the senior staff, many of whom are here today. They include Mrs. Vanner, Mr. Bain, Mr. Hagerman, Mr. Corder and Dr. Martin, who have really done a yeoman job in developing innovative approaches in the various program areas of the ministry. I see Mr. Berry here as well and Mr. Dreezer, who is recently back from the National Defence College in Kingston. I don't want to miss anybody.

**Mr. Breaugh:** You're sending your staff to the National Defence College now. Is it that bad?

**Hon. Mr. Timbrell:** No. This was not a course in the martial arts.

**Mr. Acting Chairman:** It is called civil defence.

**Hon. Mr. Timbrell:** I don't want to let the opportunity pass without saying that this was quite an honour to be bestowed on Mr. Dreezer and on the ministry in that he was chosen. As you know, the competition for inclusion in the National Defence College annual programs is very intense. It is a credit to Mr. Dreezer and the ministry that he was chosen, and we are glad to have him back.

To carry on, in recent months, as the program has continued to evolve, I think there are a number of items of interest that bear some comment today. A couple of weeks ago the ministry and the Ontario Hospital Association jointly sponsored and convened a conference for small hospitals. You may recall that I had indicated to this committee in April or May that it was our intention to convene such a conference inasmuch as we recognized that in an era of constraint in spending it is our smaller institutions that really potentially would feel any pressure to the greatest extent.

At that conference I capped the results of many months of consultation between staff of the ministry and representatives of the small hospitals of the province and my own extensive travelling through the province over the last three or four months—



**Mr. Conway:** It surely has been extensive.

**Hon. Mr. Timbrell:** —by announcing some policies which I am pleased to say were well received by the conference. In fact, just this morning I received a letter from the executive director of the hospital association indicating how much in support they were of the policies enunciated at that conference.

If I may briefly recap, it has been our concern that in the very small hospitals there is a point beyond which you simply can't ask anybody to constrain or further restrain and still maintain a viable program. I look at hospitals like Palmerston and the hospitals on the north shore of Lake Superior and in other parts of the province where they have to maintain a certain number of staff in particular categories to make the whole program viable.

In recognition of this I indicated that henceforth those hospitals with less than 50 beds would be exempted from any further application of hospital bed guidelines. For this current fiscal year they had been included in the group that was given a 10-bed cushion against their active treatment bed allocation. The effect of this will be that, looking ahead to the future in the planning for acute as well as for chronic care services, the hospitals will operate with no fewer beds than they have now.

One example is the five hospitals on the north shore of Lake Superior: Terrace Bay, Geraldton, Nipigon, Manitowadge and Marathon. I went up there on May 24, I remember it well, because we smashed up the car that morning on the way to the airport.

The Speaker was good enough to convene a meeting in Nipigon of the representatives of those five hospitals. As in so many instances, all the attention focused on the acute-bed side of the equation, which, if my memory serves me correctly, among those five hospitals meant something of the order of a 15- or 18-bed surplus over the acute-bed guidelines. It wasn't until the meeting, until I started asking some questions, that anybody started to pay any attention to the fact that, as far as chronic care was concerned, among those five hospitals they had about a 25- or 27-bed deficit.

As a result of that meeting, they agreed among themselves to plan together, in effect as a subcommittee of the Thunder Bay and District Health Council, to rationalize services, to ensure that they did develop their own chronic-care programs, because all of them certainly have chronic-care patients in what they call active treatment beds. As well, they agreed that they would come up with some plan to raise the quality of laboratory

and radiological services in those five hospitals, none of which of course is large enough to sustain a full-time laboratory technician or radiology technician.

I talked with several representatives at the small hospitals conference. They are well on their way to rationalizing between acute and chronic. I think we have to constantly re-inforce that we are talking about both and not just the former.

I understand they will probably come up with a proposal similar to what I just announced yesterday or today—I am not sure when the press release went out—for the Kenora district. We have approved a consultant radiologist to all of the hospitals in that district to ensure the establishment or maintenance of a high level of radiological services.

[2:30]

Those are examples of what has been happening in that area among the very small hospitals. I again would repeat these are exempt from any further application of the guidelines.

For the group of hospitals between 50 and 100 beds—the larger they get the little bit more flexibility they have in their operations—the 10-bed cushion will be retained. So looking to the future, their bed allocation will not fall below the planning guideline plus 10 beds. Also I would anticipate that this year's many conversions to chronic—establishment of chronic units or enlargement of chronic units in those hospitals—will continue.

I went on further to indicate that day that the government had been reviewing the capital program for all hospitals. You may recall that two years ago—Mr. Conway I am sure will recall, since he has been my critic the longest—I announced our intention for a capital program for the hospitals of \$115 million a year. That portion of my budget had to be restrained in 1978—I think it might have been at the time of the discussion of the premiums. As a result, what had been intended to be \$115 million a year had become \$86 million a year. Of course there is an outstanding list of capital projects, new hospitals, replacements, alterations, and so forth, Hotel Dieu in Kingston—

**Mr. Ruston:** We heard all about the one in Kingston on the Provincial lottery one night.

**Hon. Mr. Timbrell:** Oh, I didn't see that.

**Mr. Ruston:** Oh, yes, the Premier (Mr. Davis) was on.

**Hon. Mr. Timbrell:** Oh, good.

**Mr. Conway:** In Kingston, your old backyard.

**Hon. Mr. Timbrell:** Old, old backyard.

But there is a fairly extensive list of capital projects under way and outstanding. In recognition of this—and also in recognition of the fact there is a new source of lottery money available to us from the Loto Canada operation—the government had agreed to my request to allocate \$100 million over the next three years as the money becomes available—

**Mr. Ruston:** It's my money.

**Mr. Conway:** Wait until Joe Clark gives us Alberta.

**Hon. Mr. Timbrell:** —for hospital capital projects. So this will allow us to get back on track with the capital program we had announced and begun in 1977 and therefore to accelerate a few projects that have fallen a little bit behind.

I wish the member for Huron-Middlesex (Mr. Riddell) were here because there is one hospital in his constituency that had some concerns in the spring. It had come to meet with my staff and me and I think might even have appeared here at the committee at some point in the spring. I am thinking of Goderich.

**Mr. Conway:** He's my room-mate. I shall inform him.

**Hon. Mr. Timbrell:** We had indicated in the spring to Goderich that there was certainly a way to meet their concerns that involved conversions from active to chronic and taking a careful look at their operation. I was pleased to note—and I know that Mr. Breaugh's party noted it because you had somebody there at the conference—that the chairman of the board got up and did acknowledge the ministry had been very helpful and—

**Mr. Breaugh:** She was what you call "born again."

**Hon. Mr. Timbrell:** —had, in fact, solved their problems. This is the case in most of the hospitals we have been dealing with because we have been dealing with them on an individual basis in terms of the program.

It's interesting to note, Mr. Chairman, the present indications are, looking at the total bed situation in the hospitals, looking at acute and chronic and extended care—and I will have firmer data on this within, I would say, about a month—that we are going to end the fiscal year with no fewer beds than when we started the fiscal year. We may, in fact, be about 100 beds or so to the good, as it were, or have an increase of about 100

beds which is what I was telling the committee last spring.

One of the major disagreements I have had with some of our critics has been the zeroing in on strictly one part of the health-care system to the total exclusion of the rest, and that obviously is bound to lead to one set of conclusions which is totally inappropriate.

**Mr. McClellan:** What are the data that you will be obtaining in about a month?

**Hon. Mr. Timbrell:** I am just saying that looking at the number of beds, acute and chronic and extended care, with which we started the year and those with which we will conclude the fiscal year, the present indications are, and I will have firmer data and I will have more to say on this in about a month, I would think that we will end the year with no fewer beds overall and probably a slight increase. That is not to say that some hospitals won't have fewer beds because that will be the case. Others will have more. Many will have converted hospital beds from active to chronic or to rehab and those kinds of things.

On nursing home beds, I have recently, in the last few months at least, announced several areas where additional beds have been approved based on the local studies that have been done, 30 in Peterborough about a month ago, 28 in Timmins which I announced this morning and I anticipate adding, again based on some local studies that have been done, extra beds in several other counties within the next few weeks. As well, I expect to have in my hands within the next three or four months studies which are under way but not as yet completed in places like Muskoka. I believe Essex has one under way as well as a few other counties like that, so we can expect to see changes in that area.

I think it's worth noting, also, Mr. Chairman, because apparently it was missed this morning—this we will discuss next Wednesday I know but it's worth reading into the record that—

**Mr. Conway:** What was missed this morning?

**Hon. Mr. Timbrell:** Apparently for some reason the leader of the third party missed the announcement yesterday that we have granted money to form an additional—I think it's 21—community mental health programs in Toronto, North York, Etobicoke, York and Peel. This is money coming out of the savings associated with the move of the inpatients from the former Lakeshore Psychiatric Hospital to the Queen Street Mental Health Centre. This is in addition to the—



**Mr. McClellan:** You mean the money that you announced last spring?

**Mr. Breagh:** It sounds like a pre-release—

**Hon. Mr. Timbrell:** Gosh, I thought you would be interested in some of this—

**Mr. McClellan:** We are. We are.

**Mr. Breagh:** Where did you announce this?

**Hon. Mr. Timbrell:** This, Mr. Chairman, is in addition to the \$1.6 million which is spent on the existing outpatient programs of the former LPH which remain in existence serving the population.

**Mr. Breagh:** What was it that you announced yesterday?

**Hon. Mr. Timbrell:** The programs, Mr. Chairman, are as follows: in the city of Toronto a grant which would be the annualized cost of budget to the Parkdale Community Legal Services—I think you are familiar with them—to establish an activity recreation centre. This centre will provide social, educational and recreational programs to help former psychiatric patients and other adults and the centre will offer life skills training and referral service and a variety of activities six days a week and evenings;

Also in the city of Toronto, a \$35,000 annual budget to provide continued support to a project known as Regeneration House, which is a group home assisting in the rehabilitation of former psychiatric patients;

In the city of North York, an annual budget of \$44,800 to the North York Inter-Agency Council for a program to assist in the co-ordination of mental health services in that very large city;

A further \$9,230 annual budget to the same North York Inter-Agency Council for a program which is going to be operated by the YWCA for socially isolated women and those recently discharged from psychiatric hospital;

A \$5,230 annual budget to Community Resource Consultants for Club North York, which is going to provide social, therapeutic and recreational programs for adults who have recently been discharged from a psychiatric facility;

Over in the borough of Etobicoke, a \$150,205 budget to establish a mental health service agency which will identify community needs and co-ordinate and develop new programs, including outpatient services and home visiting for chronic psychiatric patients;

A \$67,208 budget for a crisis centre at the Etobicoke General Hospital to offer immediate care to people in severe distress, including hospitalization if necessary. That hos-

pital has a psychiatric unit which has recently been enlarged by 19 beds;

Thirty thousand dollars to provide continued support to Opportunity for Advancement, which is a preventive program for sole-support mothers who might otherwise require some psychiatric hospitalization. Counselling, referral and follow-up services are going to be provided.

Twenty-seven thousand, five hundred dollars to provide continued support to Friends and Advocates, which is a program for adults recovering from mental illness, offering group sessions, recreation and social activities in a one-to-one, befriending and support program;

Moving on to the borough of York, a \$155,130 budget for a psycho-geriatric consultative and home rehabilitative and support service, which is being sponsored by the West Park Hospital and Community Occupational Associates. This program will provide services to the northwestern area of Metro;

One hundred thousand dollars to York Community Services for the establishment of comprehensive rehabilitation services for chronic psychiatric patients aged 18 to 45, who will receive recreational, vocational and educational retraining;

Seventy-five thousand dollars to the Northwestern General Hospital for an expanded day hospital program, assessment services and follow-up clinic for psychiatric patients;

Thirty-five thousand dollars for a psychiatric day hospital expansion at the Humber Memorial Hospital;

Nine thousand dollars to the Keele Street Women's Group, which is sponsored by Mental Health York, for a socialization and life skills program for women discharged from psychiatric hospitals, and \$5,250 to Mental Health Metro for Breakthrough, a rehabilitation and educational program to reintegrate Italian-speaking women, formerly patients of psychiatric hospitals in the community;

Moving over to the region of Peel, \$143,800 for a community mental health centre at the Mississauga Hospital. This program will provide short-term intensive therapy, day care, long-term maintenance and follow-up care for psychiatric patients living in Peel;

Ninety-six thousand, three hundred and sixteen dollars for a psychiatric outpatients program at the Peel Memorial Hospital which will expand the range of outpatient psychiatric services available in the north part of Peel;

Sixty-six thousand, five hundred and forty-seven dollars to establish a crisis intervention



service at the Mississauga Hospital, which I mentioned just a minute ago, which will provide an around-the-clock service for severely emotionally distressed people;

Thirty-four thousand, six hundred dollars for an alternative housing program sponsored by Mental Health Peel to promote an optimal level of adjustment and maintenance for discharged psychiatric patients in the community;

Finally, \$14,590 for a North Peel residential support program sponsored by the Peel Regional Health Unit to provide short-term transitional residential accommodation to discharged psychiatric patients.

These grants, Mr. Chairman, as I said, come from the savings associated with moving the inpatient programs to Queen Street. These are over and above the dozen or more new programs we have announced this year in the community mental health area. I won't take the time now to read those into the record but they cover a variety of areas of the province. A combination of these represents about a 50 per cent expansion this year in the number of programs being funded by the ministry and continues the trend which we have promoted in recent years of further accent on community mental health prevention and maintenance programs.

[2:45]

**Mr. Conway:** Mr. Minister, as we prepare for next week, you will, of course, be able to prepare a neat and tidy series of figures relating in an unavoidable way these new programs from the cost savings involved with the inpatient transfer?

**Hon. Mr. Timbrell:** The original estimate was that we would have savings of \$2.6 million, and this represented half. In fact, I'd have to say that the savings are probably slightly less, and this would represent more than half of the savings.

**Mr. McClellan:** It's very helpful to have these kinds of precise figures presented to us.

**Hon. Mr. Timbrell:** Good.

During September, Mr. Chairman, I also announced a number of initiatives on the part of the ministry in the area of prevention and health education. You may recall I indicated to you a year ago in the 1978-79 estimates that we had established a new division in the ministry under Dr. Helen Demshar, for health education and promotion, which is now on its feet and running.

**Mr. Conway:** Responsible for all those nice pamphlets?

**Hon. Mr. Timbrell:** I am very pleased, Mr. Chairman, with the results to date, and their

activities. I want to run through three of the programs that we think are significant.

First is the poison prevention project, which I announced in Peterborough about a month ago. We are testing this program, which is basically aimed at getting parents to poison-proof their homes. I thought it was a little bit more serious subject—with anywhere from 25,000 to 125,000 kids poisoned a year—I thought it was a little bit more serious than that, Mr. McClellan. But, as I was saying, the basic goal is to get parents to poison-proof their homes.

Last year, there were 25,000 children, under the age of five, brought into the health-care system, most of them into emergency departments, who had been accidentally poisoned in the home. Reliable estimates are that in fact it was something in the order of 125,000 children under five who were poisoned, and that 100,000 one way or another were treated with various kinds of home remedies, at home, rather than being brought to the doctor's office or to emergency. Fortunately very few of them die, but none of them should die. Depending upon the results of this program, the program that we will eventually launch province-wide will be altered according to the reaction to it in the Peterborough area.

That is in addition to the two regional poison control centres that I announced in June, which would be after, I guess, when I was last here. These two centres are at the Hospital for Sick Children in Toronto, and at the Children's Hospital of Eastern Ontario, or CHEO, as it is known.

**Mr. Conway:** That's a good acronym.

**Hon. Mr. Timbrell:** I beg your pardon?—

**Mr. Conway:** CHEO, an acronym, sounds like revolutionary initials.

**Hon. Mr. Timbrell:** It makes it easier. The centres will provide treatment services, of course, to patients on a 24-hour-a-day basis. They are acting as a major reference source to all Ontario hospitals on toxic substances and antidotes and they are going to help us to develop even better statistics and the educational programs to combat the problem.

I would invite any member who is interested to perhaps call ahead and pay a visit to the Poison Control Centre at Sick Kids' down the street. I think you'd find it rather interesting, the massive amounts of information that they've got to keep on circular files and microfiche to be able to answer a doctor who calls from Marathon or wherever to find out how to deal with a particular household product or a household plant or animal. It's really quite amazing, the information they

have to have at their fingertips, and the ladies who run it do an amazing job.

The second program for which I have high hopes is the program dealing with junk foods in the high schools. We all recall from student and/or teaching days the really rather pathetic proliferation of convenient but very low-in-nutrition foods—

**Mr. Conway:** Another strike against free enterprise.

**Hon. Mr. Timbrell:** Not at all; I'll come back to that.

The program is an attempt to promote a trend which we think is there anyway but needs a shot in the arm. When I was in Sudbury about three weeks ago I indicated in an address at the Sudbury Secondary School that in the spring of 1980 we would be making awards of \$1,000 to each of the 20 successful applicant high-school student councils which submitted proposals to encourage improved nutritional habits among their peers and which show the best promise for continuing those trends.

The competition will close on February 1, and I am pleased to say that we have had a great deal of interest shown in this by the student councils. We purposely decided to go that route rather than to the administration, because we think if we can motivate the students, that will go a lot further to motivating their fellow students than if it comes, as it were, from on high, from the administration, whether it's the principal, the board or whatever. As I say, the interest in that is very gratifying.

**Mr. Conway:** Tell Joe Clark to start drinking milk.

**Mr. Breaugh:** Send him a poster.

**Hon. Mr. Timbrell:** One of the major on-going problems in health care, of course, is the maintenance of a high level of immunization among the public. We began this year a widespread campaign aimed at promoting higher levels of immunization and reminding people that diseases like polio, notwithstanding what they might have thought, are not eliminated; that they can and do, as we have experienced in the last two years, crop up from time to time; and that it's a simple matter, either through the public health clinics or at the doctor's office, to be immunized on the schedule recommended against things like diphtheria, poliomyelitis, measles and so forth.

Between now and next spring the Ministry of Education will develop the appropriate legislative vehicle to back up a campaign that will begin in the schools in the fall of 1980, which will require parents to sign one

way or the other, either that they are granting permission for their children to be immunized—again, according to the schedules recommended—or that they are denying that permission and assume full responsibility for any consequences.

We anticipate that campaign will significantly increase what is already a very high level of immunization in the province; we are well over 80 per cent, which is one of the highest levels of any jurisdiction in the western world, but obviously there is still room for a lot of improvement, because certain of our health units get well over 90 per cent. I am thinking, for example, of Perth, where Dr. Tamblyn has developed a program; they are up to around 92 or 93 per cent immunization in that area.

Anything we can do to back up the efforts of the medical officers of health and their staffs and the schools and the doctors in the community will obviously be in the best interests of the children. It probably costs us about \$5 or \$6 to immunize against poliomyelitis, compared with the tens if not hundreds of thousands of dollars it costs us to maintain somebody throughout his lifetime as a result of the effects of paralytic polio. I think I'll come back to that.

On the OHIP side, Mr. Chairman, the growth and utilization continues to the point where we now, in the health plan, are paying on average about 250,000 claims every working day for services provided to the populace of the province. That works out to better than seven or seven and a quarter claims per person per year, which is something in the order of about a 30 or a 35 per cent increase in the use of health services in the last five or six years.

You will recall, I am sure, going back about a year ago, the predictions which were being made at that time, that the numbers and percentage of doctors opted out, or not participating directly in the health plan, would hit 30 or 40 per cent. There are a number of references in Hansard attributable to a spokesman on the opposition side of the House.

I am pleased to say the number and percentage of nonparticipating physicians did peak in February as had been predicted at this time last year. I'll come back to why that prediction was made and the significance of February or the first quarter of the year. In fact, it has actually been reduced slightly in the last eight months. At present, 17.8 per cent of the physicians are nonparticipating, which is the same as it has been for the last couple of months, but is down from the 18 which was the peak in the first quarter.



**Mr. Breaugh:** That's kind of dramatic.

**Hon. Mr. Timbrell:** As a matter of fact, I am glad you made that observation, because it is interesting to note that between 1973 and the present day the population of Ontario increased by eight per cent, but the number of physicians in the province increased by 19 per cent or approximately 2,000 in a six-year period. Not only do we not have increasing numbers of doctors opting out or nonparticipating—it has stabilized—but we have more physicians participating in absolute numbers and in terms of ratio to population than we had six years ago.

**Mr. Breaugh:** Did you ever find out who has opted out and where?

**Hon. Mr. Timbrell:** I'll be answering that tomorrow.

**Mr. Breaugh:** Do you mean you're finally going to answer it?

**Hon. Mr. Timbrell:** It took a lot of time.

**Mr. Breaugh:** Do I get a gold lollipop and finally get an answer out of the minister?

**Mr. Conway:** Does your last comment have anything to do with your concern about a 33 or whatever per cent increase in utilization?

**Hon. Mr. Timbrell:** I think there are a number of factors that contribute to that, which we have discussed before.

**Mr. Conway:** Both ways.

**Hon. Mr. Timbrell:** Certainly, there is an increase in physicians. As you know, my predecessor made the estimate about four years ago that every time a new physician came on the roll, as it were, it cost at that time about a quarter of a million dollars per physician. I've not tried to cost it but it's probably closer to \$350,000 to \$400,000 per physician per year now.

**Mr. Conway:** Only Bryce Mackasey costs more.

**Hon. Mr. Timbrell:** Who could be more deserving? As you know, in June we settled on a new mechanism for negotiations which is currently in use, and the negotiations are under way. I think the fact the situation has stabilized in the last eight months lends even more weight to what I was saying a year ago about the expiration of the AIB program.

You recall, as far as the application of that program is concerned with respect to doctors, they individually came out from under AIB controls, depending upon when their first fiscal year after April 14, 1978 occurred. At this time last year I was predicting the numbers would peak in the first quarter. They did. They have slipped back a bit since then,

and I am optimistic that when we finalize our negotiations there will be a further significant recession in those numbers. But I would emphasize again that, notwithstanding those figures, we have more participating physicians in the province than we had six years ago.

[3:00]

**Mr. Breaugh:** Do you say you've finally figured out who these people are and where they are?

**Hon. Mr. Timbrell:** I'll be answering that tomorrow.

**Mr. Breaugh:** We don't want to blow the glorious announcement. It has been six months.

**Hon. Mr. Timbrell:** This is something that I'm sure there'll be a chance to discuss further next week when the leader of the third party is here. I'm looking forward to that discussion.

**Mr. Breaugh:** I feel a sense of drama building to this moment.

**Hon. Mr. Timbrell:** I hope.

**Mr. Conway:** When is he going to join us? I hear the member for Oshawa (Mr. Breaugh) is the heir apparent.

**Hon. Mr. Timbrell:** More heir than apparent. Speaking of drama, hype and anticipation, there's been an awful lot of drama built up around the province over the last couple of months about these tours that were being conducted by the leader of the third party, the critic and certain other members.

**Mr. Breaugh:** A good deal more valid than the minister's tours.

**Hon. Mr. Timbrell:** We must compare clip-pings some day. I have to say that if this material which was released this morning is the end result of all that, it's absolutely pathetic—

**Mr. Breaugh:** No more pathetic than the nutritional poster program.

**Hon. Mr. Timbrell:** —that party would start out having decided what they wanted to find and, not being able to find facts to support the theory they wanted to put across, they then had to resort to this very, questionable series of allegations this morning. I'd like to just go through them one by one, and we'll have more to say on this next week.

**Mr. Breaugh:** I think you're just worried, but let 'er fly.

**Hon. Mr. Timbrell:** You make certain statements, I'm not about to let half-truths or untruths go unanswered.

**Mr. Breaugh:** That's not parliamentary now. Be careful.



**Hon. Mr. Timbrell:** Oh yes it is; it's quite parliamentary.

**Mr. Breaugh:** No, it's not parliamentary. Refer that to procedural affairs; we'll deal with it.

**Hon. Mr. Timbrell:** The first thing is that at several points in the statement of, and in the questions which were put to, the leader of the third party afterwards he kept referring to medicare as something which the NDP created, referring to Saskatchewan. I wish, if he wants to use Saskatchewan as his model, that he would look at Saskatchewan and what is actually happening in Saskatchewan.

Recently, as I've just been discussing, there's been a lot of attention paid to the number of non-participating physicians in the province or opted-out physicians. Some people have even gone so far as to try to leave the impression that the numbers continue to increase, which of course is not the truth.

**Mr. Conway:** Repeat that.

**Hon. Mr. Timbrell:** It's not the truth.

**Mr. Conway:** What's not the truth?

**Hon. Mr. Timbrell:** That the numbers of physicians opting out or non-participating continue to increase. In fact, as I've just explained to you, they've actually receded slightly.

**Mr. Cooke:** It doesn't help those patients who need neurosurgery in Windsor.

**Hon. Mr. Timbrell:** How many more doctors do you want to drive out of Windsor? You've already driven out one neurosurgeon; how many more do you want to drive out of that city?

**Mr. Cooke:** I drove him out?

**Hon. Mr. Timbrell:** We'll come back to that, yes. The fact is that in the province of Saskatchewan today between 30 and 40 per cent of the physicians practising in that province are extra-billing some of their patients for some services, which is what is known euphemistically as mode three.

**Mr. Breaugh:** We have got that. We're in close agreement here now.

**Hon. Mr. Timbrell:** I always know when the NDP are on weak ground when they start to get silly. Obviously, they must feel their feet sinking out from under them.

**Mr. Breaugh:** That's silly, I know, but what the hell, let's be fair; we've only had one go in the last two years.

**Hon. Mr. Timbrell:** I'm sorry, I thought you were talking about Saskatchewan.

**Mr. Breaugh:** Oshawa. I always talk about Ontario when we're in the Ontario Legislature.

**Hon. Mr. Timbrell:** Let's talk about Saskatchewan for a moment, because you like to hold it up as the example of what you did, your great achievement, what a wonderful thing it is and what a great example for the country. There you've got between 30 and 40 per cent of the doctors under mode three, extra-billing for some of their services.

**Mr. Breaugh:** Some of the time.

**Hon. Mr. Timbrell:** Since 1962 there have been three modes available to a physician. He could either bill the insurance commission directly or he could, and still can, bill a third party carrier directly at the same rate as the, I think it's called the MCIC, and they would in turn be reimbursed by the MCIC; or—and this is where the 30 to 40 per cent fit in—they can elect to charge some of their patients some of the time for some services. Of course, they could provide a couple of services to a patient on a given day and bill MCIC for one of them and bill the patient for the other and he collects back the MCIC payment and actually pays the difference.

That's, of course, not talked about very often by the leader of the third party because I suppose that might be construed by some as being a form of opting out, and in fact was even defended by the leader of the New Democratic Party in that province, who happens to head the government, Premier Blakeney, in an extensive interview with the Regina Leader-Post, I think it was February or March, as an appropriate mechanism to ensure the maintenance of the freedom to practise medicine and as a form of, I think he called it an escape valve, that they could tell if there was a difficulty in negotiations or in the relationship with the profession. That sort of thing, of course, is never talked about.

**Mr. Breaugh:** You're talking about it.

**Hon. Mr. Timbrell:** Yes, I think somebody had better. If you're going to promote a particular model then we'd better understand that model.

There's also the fact that in a conversation I had with the Deputy Premier of Saskatchewan over the summer it was interesting to note that most of their doctors in the province are, in fact, from overseas. You might want to check into that.

**Mr. Breaugh:** Are you suggesting there's something wrong with that?

**Hon. Mr. Timbrell:** I'm suggesting that what happened, in fact, was that they have

had a problem in retaining their physicians in the province. To my knowledge, they are one of the last provinces that still promotes their immigration into the province from overseas.

**Mr. Breaugh:** Are you suggesting there's something wrong with that?

**Hon. Mr. Timbrell:** I'm suggesting that it should be possible—and it certainly is possible in most provinces—to meet our physician requirements from the resident and landed immigrant population of the country rather than having to go overseas to find our physicians. That's what I'm suggesting.

**Mr. Breaugh:** I see. It's a very refined suggestion.

**Mr. Cooke:** Get us a neurosurgeon for Windsor then.

**Mr. Breaugh:** I wouldn't want you to be accused of being racist or anything.

**Hon. Mr. Timbrell:** No, that's not the point at all. You're missing the point altogether, but that's not surprising.

**Mr. Breaugh:** Try it again.

**Hon. Mr. Timbrell:** What amazed me—I've read the clippings and I've read very carefully the material which was released this morning and, for instance, they start off in the material this morning talking about Hamilton. When you went to Hamilton, as just a matter of interest, did you go to MUMC, the McMaster University Medical Centre?

**Mr. Breaugh:** Yes.

**Hon. Mr. Timbrell:** Did you go to the perinatal unit?

**Mr. Breaugh:** Yes.

**Hon. Mr. Timbrell:** What did you think of it?

**Mr. Breaugh:** I thought it was quite good.

**Hon. Mr. Timbrell:** Good. It didn't come out that you looked at things like the perinatal program, or that you went to Saint Peter's or to Chedoke and looked at the chronic care programs there, or that you went to St. Joseph's and looked at the coronary care program there, or that you took a look at the chronic home care program in Hamilton or the existing patient co-ordination services—

**Mr. Breaugh:** You're going to have to use question period for this. You're going to have questions about this every day.

**Hon. Mr. Timbrell:** The point is, of course, I'm not sure which number it is but I think it's number four or number five or Murphy's Law, that if you fiddle with some-

thing long enough you'll break it. Of course, the third party started out with a—

**Mr. R. F. Johnston:** A very dangerous question—Freudian slip

**Hon. Mr. Timbrell:** No, listen; if it touches home. The point is that the party to my extreme left, which is only appropriate, started out with a particular thesis which it felt hard-pressed to try to substantiate. The fact of the matter is that if you go to Hamilton you're going to find there, in the perinatal unit at McMaster University Medical Centre, a program which has saved, now, literally dozens and dozens of extremely fragile and very small premature babies. You are going to find programs at St. Peter's in Chedoke that have not only added years to people's lives, but have added quality to people's lives in those extra years.

You are going to find in the oncology programs, in the cardiovascular programs, in the orthopaedic programs, in the Civic and St. Joseph's programs, steps which have relieved a great deal of human suffering. None of that is mentioned.

**Mr. R. F. Johnston:** I didn't ask that—

**Hon. Mr. Timbrell:** When you went to Thunder Bay, did you go and take a look at the new cancer clinic which I opened last year? Did you go and take a look at the new CAT scanner at McKellar Hospital in Thunder Bay? Did you go and take a look at the new 100-bed Heritage Villa Nursing Home in Thunder Bay? Did you go and take a look at any of these programs, such as the chronic care program in Thunder Bay? It never comes out.

**Mr. Cooke:** We couldn't find it.

**Mr. Breaugh:** We aren't here for the ministry; we want to check that budget.

**Hon. Mr. Timbrell:** This is the amazing thing. Apparently you did all this in two weeks' time, yet people who have spent years in running hospitals in the health care system, people who have spent years working in the ministry to help in the development of programs, people who have spent years in accreditation reviews of hospitals, aren't finding that the system is falling down around our ears, as you would like everybody to believe. In fact, the system is alive and well and functioning better than it ever has.

**Mr. McClellan:** Maybe you will start hearing some of these things.

**Hon. Mr. Timbrell:** In here you talk about Atikokan. You say in your statement that three doctors in Atikokan have to take their holidays in the area so they can be available



for operating room work in case of emergencies. We checked this out with Dr. Copeman, who runs our underserved area program—and very well at that, I might add. He indicates to me we have two doctors in that area who are operating in the underserved area program and that meets the needs of the area.

We have what is called a locum pool. That is a mechanism by which we provide people to go into these communities to allow the physicians to get away for holidays or continuing education. Yet we have never had a request from Atikokan; and that pool is well known.

The most amazing thing is to read your comments on Elliot Lake and Blind River. I understand that when you first approached the hospital—when would that have been, May?—you were told—and I think you made the call yourself, Mr. Breagh—there were no problems there but that if you wanted to come that was fine, it was up to you.

I visited Elliot Lake on September 22 or 23, at which time I met with the boards of the Elliot Lake and Blind River hospitals. You may know that both hospitals belong to the Sisters of St. Joseph of Sault Ste. Marie. At that time the chairmen of the two hospitals handed me a role study for which they had asked me for funds to carry out last winter and which the ministry had agreed to pay for. I am trying to remember who did the study for them; I think it was EHE, a firm in Ottawa. That role study had not only been endorsed but recommended by the boards of both the Blind River and Elliot Lake hospitals.

I saw the administrator of Elliot Lake and the chairman of the board again at the small hospitals conference on September 28, which means it would have been September 21 that I was in Elliot Lake. But rather than what you describe, they propose to reduce the number of beds in the two hospitals by one third—from 4.5 beds per 1,000, which is where they are presently, to three beds per 1,000.

They proposed that there be fewer nursing-home beds in the district than even the minimum guidelines we use would provide, and fewer chronic-care beds than even our minimum guidelines would provide.

[3:15]

To do this, they go on to propose a series of outpatient programs at the hospital for day surgery, programs for addiction of various kinds in the community and expansion of the role of the health unit. I may say that that particular health unit has been given the go-

ahead to form a chronic home-care program in that particular area, which will be expanding into the Elliot Lake part of their district.

That's coming from the people who own, who run and who from day to day are responsible for those hospitals. It is not the kind of material that you get from a one-hour swing through there for lunch with the assistant administrator. I think you were there on September 28. It's quite a contrast.

I might say that in the exchange this morning the leader of the third party zeroed in on Sault Ste. Marie. Obviously, he is not aware that a contract has been agreed upon by the Sault clinic and the ministry. He correctly pointed out that the Sault clinic has had a very positive effect in that community, not only on the status of the health of the people but in terms of hospital utilization. As you will know, because I know you have read extensively in this area, our rate of hospital utilization in this province is much higher than in many jurisdictions to the south of us.

In fact, if you compare the average rate of hospitalization in terms of patient days per one thousand population among the patients of health maintenance organizations in the United States, it's something like 500 days per one thousand population per year there, while we're presently running in excess of 1,300 patient days per thousand population per year. That's quite a contrast.

The Sault clinic, in going on 18 years of operation, has had a very positive influence in that community. Some of the estimates range as high as 40 per cent fewer patient days. I may say too, that the rate of hospitalization in the province overall has gone down as well, if I can remember the figures correctly, by something in the order of 13 per cent in the last six years.

Mr. Ramsay: May I interject at this point? I'm looking at this press release on Sault Ste. Marie and, actually, I'm very pleased that the worst Mr. Cassidy could find was that the clinic has been hassled by the ministry and by the College of Physicians and Surgeons. But it doesn't say anything about inadequate funds or inadequate service. It doesn't refer to either of the two hospitals in Sault Ste. Marie, of which I happen to be very proud.

Mr. Breagh: What is their projected deficit this year?

Mr. Ramsay: The deficit is being studied right now by the ministry.

Mr. Breagh: What is it? How much?

Mr. Ramsay: Roughly \$250,000 is what they're anticipating.

Mr. Breagh: Nothing to get excited about.



**Mr. Ramsay:** However, there is a role study going on and the consultants are in at the present time.

**Mr. Breagh:** What consultants are in there?

**Mr. Ramsay:** Woods Gordon are doing the role study between the two hospitals.

**Mr. Breagh:** What's the tag for the Woods Gordon role study?

**Mr. Ramsay:** Approximately \$38,000.

**Mr. Breagh:** Who are the consultants who are being used?

**Mr. Ramsay:** I'm not sure.

**Mr. Breagh:** Does anybody know what the price tag for those consultants is?

**Mr. Ramsay:** The price tag is based on the saving, I understand.

**Mr. Breagh:** Do you know what it would be?

**Mr. Ramsay:** They are talking about a saving in the range of \$750,000 at the General Hospital.

**Mr. Breagh:** And how much would the consultants get from that?

**Mr. Ramsay:** I haven't any idea.

**Hon. Mr. Timbrell:** I think that's an interesting point and an interesting development in the last year and a half. It was about a year and a half ago that I started the practice of insisting that every hospital that came in with a budget appeal—and this is something that goes on every year—had to show that it was spending the money it is receiving now in the most effective way possible.

Initially, that meant they had to bring in private sector consultants. There are a number of companies that are in the business of doing analyses of such operations and making recommendations as to how the same services can be provided but in a more cost-effective manner. Since then, the ministry has given a grant of a quarter of a million dollars to the Ontario Hospital Association to allow hospitals to develop their own in-house capabilities to carry out such analyses. There has not been a case yet, not one, where such external analyses have been done, whether it's by the OHA cost-effectiveness team, which is becoming more and more active, or by private sector consultants, that haven't resulted in significant savings, which can then be re-directed into other programs. I might say we have also engaged such consultants ourselves.

**Mr. Breagh:** What's the price tag? How much is it costing the ministry to use these consultants? And who are they?

**Hon. Mr. Timbrell:** I'm not sure which ones we used. I haven't got that information

in front of me. But the savings have been considerable. I'll get the figures for you.

**Mr. Breagh:** How much did you say the savings were? Considerable?

**Hon. Mr. Timbrell:** I'll get you the exact figures, but it's rather interesting that you would be opposed to finding ways to save money; that you only think of ways—

**Mr. Breagh:** I don't quite recall that we said that. When did we say that?

**Hon. Mr. Timbrell:** Well, I think that's the net effect.

**Mr. Breagh:** Oh, I see.

**Hon. Mr. Timbrell:** You're saying it's not a good idea to use outside consultants of any kind.

**Mr. Breagh:** Did I say that?

**Hon. Mr. Timbrell:** It's an interesting proposition you seem to be advancing—but not unexpected.

**Mr. Breagh:** We're just trying to help you, Dennis. We know you're in trouble here, and we're trying to get you through this.

**Hon. Mr. Timbrell:** Oh? I may also say, continuing on from what the leader of the third party had to say this morning about the Sault clinic—

**Mr. Breagh:** You're mad because he praised the Sault clinic; is that it?

**Hon. Mr. Timbrell:** —the local member and I, and I think everybody associated with the clinic, are quite prepared—

**Mr. Breagh:** What you're saying is that Michael shouldn't have praised the Sault clinic; is that it?

**Hon. Mr. Timbrell:** Let me finish.

**Mr. Breagh:** What are you saying?

**Hon. Mr. Timbrell:** Don't get so upset.

**Mr. Breagh:** I am just trying to explain. I'm not upset yet. When I'm upset I throw chairs.

**Mr. Acting Chairman:** Gentlemen!

**Hon. Mr. Timbrell:** The leader of the third party went on this morning to say, first of all, that if everybody in the province were practising medicine in a setting like the Sault clinic, and if everybody had to go to doctors in places like the Sault clinic, the savings would be something like \$800 million a year. That's a lot of money. I'm not exactly sure how he arrived at that figure. But what he's saying is that he would find a way to cut \$800 million out of the hospitals. Now, \$800 million out of the hospitals represents 40 per cent of government spending on hospitals.

One hundred and twenty-five thousand people are—

**Mr. Conway:** How did he arrive at the figure of \$800 million?

**Hon. Mr. Timbrell:** The leader of the third party—I know you'll be interested in this—was saying this morning that, taking the experience in the Saute clinic, if everybody in the province were forced to practise medicine out of a clinic—

**Mr. Breaugh:** Wait a minute. Forced? That's not democratic.

**Hon. Mr. Timbrell:** —and if everybody were to take their physician services from physicians operating in clinics, the savings that could be redirected—have you got his exact words there?

**Mr. Breaugh:** Yes. Read the exact words; that'd be a change.

**Hon. Mr. Timbrell:** The savings that could be redirected would be of the order of about \$800 million a year. Where is it going to come from? Obviously it's going to come from the hospitals, because that's the point he was making—

**Mr. Breaugh:** Read the direct quote; it's not quite that tight.

**Hon. Mr. Timbrell:** —that the significant savings in hospital operations would be due to the reduced hospitalization. If you look at the hospitals, that means something of the order of 40 per cent. Our spending on hospitals this year is about \$2.25 billion; so it's actually a bit less than 40 per cent. I'll be charitable and say 35 per cent.

**Mr. Breaugh:** Thanks.

**Hon. Mr. Timbrell:** If you consider that about 80 per cent of the money spent on hospitals is for wages and salaries, I suppose that means something of the order of 28 per cent of the staff employed in the hospitals—or in other words, about 35,000 people—could likely be let go.

(Laughter.)

**Hon. Mr. Timbrell:** Look at your leader's own remarks. That's what he was suggesting this morning. He said that if that pattern were duplicated across the province, "our figures show that \$800 million could be saved and redirected to community programs" et cetera.

It reminds me of about 15 or 16 months ago, when the Leader of the Opposition was telling me in committee, downstairs, and in the House—I'm not sure I'm quoting him exactly—that we could slash \$50 million out of the budget of the Ministry of Health; there would be no trouble at all. Of course,

that's a different tune from what he was singing earlier this year. But I thought it was an interesting proposal from the leader of the third party to cut \$800 million, eventually, out of hospitals; you couldn't take 35 to 40 per cent out of hospitals without closing whole hospitals and significantly reducing, by probably something in the order of 35,000 people, those employed in the hospitals.

That is what your leader was advocating. That is the net effect of it, so you had better recognize it.

**Mr. Breaugh:** You had better get those bifocals cleaned, Dennis. You are not only reading between the lines, you are reading the edge of the page now.

**Hon. Mr. Timbrell:** Fortunately, I am not up to that yet; not up to bifocals yet.

**Mr. Breaugh:** You should be; you are past the stage.

**Hon. Mr. Timbrell:** If you are going to throw stones, you shouldn't live in a big glass house, and that is where you have been.

**Mr. Breaugh:** Somebody write that down, "If you are going to throw stones, you shouldn't live in a big glass house."

**Hon. Mr. Timbrell:** That's original.

**Mr. Breaugh:** That's catching, that's catching. Boddington, did you write that?

**Hon. Mr. Timbrell:** I may copyright that.

Finally, Mr. Chairman, I do hope that the leader of the third party will be here next week, because there are a couple of other things that I think are interesting. The very worst thing you could find in Ottawa is that somebody is keeping the Kleenex under lock and key, the very worst thing.

**Mr. R. F. Johnston:** And they're using toilet paper instead of Kleenex.

**Hon. Mr. Timbrell:** He doesn't tell us whether it is a supply cupboard that includes cleaning chemicals and perhaps some non-prescription drugs, he doesn't tell us anything about that, but that is the worst thing he could find in Ottawa. Again, I don't know if he ever goes home. Does he still live on the island, or does he go home once in awhile?

There is no mention in here of the new Ottawa Health Sciences Centre General Hospital, which will open in 1980. There is no mention in here of the new 77-bed rehab hospital which is being built under the auspices of the Royal Ottawa. There is no mention in here of the old Ottawa General being converted to a chronic-care facility,

first for 150 beds and eventually for 200 chronic beds. There is no mention in here of the rebuilding of the Ottawa Civic, which has already begun. There is no mention in here of the new commissary facility which is being built by a group of six Ottawa hospitals. There is no mention in here of the new cancer clinic that I opened in Ottawa last year. There is no mention in here of the two new CAT scanners in Ottawa in the last few years. And, the list goes on; I don't know if he ever goes home.

I am pleased to know that the worst thing that he could find in Ottawa is that somebody has got the Kleenex under lock and key.

Coming to Peterborough, this is where I am afraid that somebody has misinformed him. He makes the statement that the health unit was promised 75 per cent provincial funding and today is only receiving 50 per cent. That would have the casual observer believe that I, or somebody, had gone down to Peterborough, or they had come up to Toronto, and we had said, "Right, we are going to pay you 75 per cent." That I had said that and I had reneged, that they are only getting 50 per cent. That would be a terrible thing.

The fact of the matter is that the very first delegation I ever met as Minister of Health, and it came three hours after I was sworn into the portfolio on February 3, 1977, was a delegation from the Peterborough County-City Health Unit to deal with the question of funding. It has been the policy of the ministry for well over a decade to encourage the creation of district health units so that you have got a large enough population base to support a whole range of programs and services.

I said to them at the time, and this was, I must say, against the advice of the staff, that if they would merge their programs between the Haliburton-Kawartha-Pine Ridge Health Unit and the Peterborough County-City Health Unit, I would increase their funding to 75 per cent right away. That was not acceptable at the time. I am meeting with them again on—I think it is the 20th of this month; we will discuss it again, but that offer still stands. So I think the record needs to be set straight on that.

**Mr. R. F. Johnston:** There are more things from Peterborough, though. Heavens, there are clerical workers making decisions in emergency wards. We haven't told you them all yet.

**Hon. Mr. Timbrell:** Oh, I see.

**Mr. R. F. Johnston:** We will get to lots of other stuff, don't you worry. We haven't told you them all yet. We've got lots of other stuff, don't you worry. We've got lots more. [3:30]

**Hon. Mr. Timbrell:** I see. The fact of the matter is if this is some kind of a court and you're laying charges, on the basis of this kind of information and the things you've said on your tour around the province it seems to me a motion to dismiss the charges would be in order.

**Mr. Breaugh:** We haven't even got the gallows erected yet.

**Hon. Mr. Timbrell:** Right. The last thing I want to comment on in the remarks—

**Mr. Breaugh:** Thanks.

**Hon. Mr. Timbrell:** I've got a lot to go yet—this morning is in the area of copayment in the chronic hospitals. It's a year ago next week—I think it was October 17, if memory serves me correctly—that the select committee on health care financing made its report.

**Mr. Breaugh:** You sound like a broken record.

**Hon. Mr. Timbrell:** I think the record needs to be repeated, repeated and repeated because you fellows have a happy facility for very short memories.

**Mr. R. F. Johnston:** I'll be back.

**Hon. Mr. Timbrell:** Good, hurry back. In that report—I'm sorry I don't have it in front of me—the members of all three parties unanimously recommended that we introduce a copayment in the chronic hospitals to equalize the financial burden or impact in the nursing homes. Do you have the wording for that handy? I accepted that recommendation and introduced it in the early part of this year.

Ever since that time, notwithstanding the position that your members took, and which was caucused—you may recall that the report—

**Mr. Breaugh:** Wait a minute, that is not accurate.

**Hon. Mr. Timbrell:** My information is—

**Mr. Breaugh:** Your information is wrong.

**Hon. Mr. Timbrell:** If you check the record—

**Mr. Breaugh:** Your spies in our caucus are unreliable and should be dismissed.

**Hon. Mr. Timbrell:** —of the select committee, you'll find they were delayed by several days because the representatives, Mr. Mackenzie and Mr. Warner, had to discuss the draft report with the caucus before they would agree to sign it. Mr. Conway is here.



He can correct me if I am mistaken, but that is my recollection. In fact, they did finally agree.

**Mr. Breaugh:** Sean, you're dead.

**Hon. Mr. Timbrell:** There being no dissent, I take that as being in the affirmative. Ever since then, I really wonder when you guys stand for anything. You take that kind of position, and it's a perfectly understandable one, one which is supported by the Senior Citizens' Advisory Council of Ontario, the hospital association, any number of groups, advisory and otherwise in the province, and certainly one which I can support and have supported, yet, as soon as it's accepted—and there's always bound to be some controversy surrounding the introduction of that kind of policy—you start to squirm out from under it. "We didn't mean it quite like that," and, "No, you should withdraw it," and, "We want to think about that."

The fact of the matter is it made sense to you a year ago. I suspect that privately it makes sense to you now, but like so many other things, you see a chance to play politics with the health-care system. Never let the facts stand in the way of a good headline, and you take this kind of a position.

There are many other things I'd like to get into about the remarks from the leader of the third party this morning. I hope we'll hear more of the kinds of things the member for Scarborough West alluded to in the days to come, if they fall into the category of what we've seen so far.

I have to say though there was some reference this morning—this just occurred to me—to an example of what I think is a pretty low level in the public life of this province. I'll direct my remarks to the member for Oshawa.

A number of weeks ago you put out a press release based on a document which had somehow come into your possession—how is of no consequence to me—from the Wellesley Hospital. This document was apparently a working paper prepared well over a year ago by some of the physicians in that hospital. It was a document that had a section at the end of it headed "Conclusions and recommendations" which was totally blank, yet you put that out to purport to show three people had died as a result of bed closures.

The document didn't say that. When approached, the chairman of the group, Dr. Bean, said that was not the case. In fact on June 11 of this year he sat at this committee and asked the rhetorical question, "Did it adversely affect medical care? I can't state."

He went on to indicate that they had in fact surveyed, and a judicious medical advisory committee would do the same in any hospital, and couldn't state that care had been adversely affected. Yet you purposed to say that three people had died.

Even that day the administrator—

**Mr. Breaugh:** Would you care to elaborate on when I purported to say that? Would you read the press release that I put out with the document and any subsequent statements that I made?

**Hon. Mr. Timbrell:** I'd be glad to.

**Mr. Breaugh:** I think you should.

**Hon. Mr. Timbrell:** This is your statement of September 12.

**Mr. Breaugh:** Yes, read it.

**Hon. Mr. Timbrell:** "According to a report prepared at Toronto's Wellesley Hospital, bed closures resulting from Tory restraints caused three deaths."

**Mr. Breaugh:** That's what it says.

**Hon. Mr. Timbrell:** That is not what the report that was in your possession for two weeks prior to your releasing it said.

**Mr. Breaugh:** That is what it said.

**Hon. Mr. Timbrell:** That is not. The chairman of the group who carried out the survey indicated at this committee on June 11 that they could find no such evidence.

**Mr. Breaugh:** Despite the fact they'd done this report.

**Hon. Mr. Timbrell:** The day that you released the report, that doctor, Dr. Irwin Bean, was approached and repeated what he had said to the committee in June.

**Mr. Breaugh:** The day that I released the document he wasn't around.

**Hon. Mr. Timbrell:** The administrator of the hospital was approached and confirmed what Dr. Bean had said, that notwithstanding the fact that they'd been very vigilant in keeping tabs on what was happening in their hospital, they could not arrive at such a conclusion.

**Mr. Breaugh:** But they did in their report.

**Hon. Mr. Timbrell:** But they did not. There is no conclusion and no recommendation at the end of that report.

**Mr. Breaugh:** They did.

**Hon. Mr. Timbrell:** In fact that is not what the report says. What the report said was—let me find the relevant section—"Medical care adversely affected," is the heading. "Thirteen cases were reported of which three died." Thirteen cases were discussed, and this is what Dr. Bean went on to say in

June, and when you released this on September 12. Thirteen cases were discussed. Three of the people had died; but they could not and they did not conclude that any restraint in the budget of the hospital, or closure of beds for the summer, caused those deaths.

You say in your statement, "Bed closures resulting from Tory restraints caused three deaths." That sir, is categorically untrue.

**Mr. Breaugh:** That, sir, is categorically untrue.

**Hon. Mr. Timbrell:** Mr. Chairman, again, we are faced with the situation where the members of that party, for their own political reasons, will not let the facts, or the statements of responsible people like the physician, Dr. Bean, or the administrator, Mr. Thornton, stand in the way of a good headline, or stand in the way of their political drive.

I look forward to the next few days when we can further discuss these kinds of things; certain inquests that have been referred to and the actual results versus the kind of statements that were made this morning and have been made in recent months and to further discuss the successes of the health-care system in this province, which are considerable.

**Mr. Chairman:** Does the critic for the Liberal Party have a statement?

**Mr. Conway:** I have a few introductory comments. They are not going to be particularly long. I would expect them to be no more than 15 minutes, and I understand at that point we'll adjourn for the day.

**Mr. Chairman:** Before you go on, am I correct in assuming that the NDP critic will not make a statement today?

**Mr. Breaugh:** Yes.

**Mr. Chairman:** Are we then in agreement that the committee will conclude at the end of the statement made by the Liberal critic? Is that agreed? So agreed. Proceed.

**Mr. Conway:** I want to begin today by offering a few observations as one who has sat on this committee now for many weeks this particular year, and for the third successive year in my capacity as critic for health matters in the Ontario Liberal Party.

I listened with great interest to what the minister had to say in his opening remarks and was impressed by perhaps what was not said; I want to discuss some of what I thought were notable absences insofar as his introductory survey was concerned.

There have been some developments, and he has directed our attention to them, since

we last met here in June 1979, and which I think do deserve some passing comment. I, as one member, and speaking for my colleagues, Mr. Riddell and others, whose particular concern is well known to the honourable minister, we are appreciative that the government and the ministry has at last recognized that the hospital sector had been pushed too far. We believe the restraint ethic that had been the guiding hand of ministry policy in recent years was seriously threatening the viability of quality health care in that sector. My colleagues much appreciated the minister's announcements, both in, I believe, April and subsequently in August or September when he announced a redirection of new lottery funds to hospital capital programs.

I must say—and I speak here, perhaps, as a private member—it warmed my heart a bit to see the decision taken by the ministry to establish some better priorities, to take the available lottery moneys and to apply them where it is clear real and immediate and serious public policy requirements lie. If I had my way and I were in a position of sole authority, there would be a significant move made against a goodly portion of the Wintario funds, not entirely on financial grounds but certainly as an indication to the public in this province that we are serious as a legislature about establishing meaningful priorities at a time when the economy is not as expansive as we might like it to be.

I wanted to say at the outset that I think the decision taken by the government was a right and proper one in directing those funds to the hospital sector which I believe had been strangled within an inch of its life in some cases.

I want to underscore the point about priorities, because I find it increasingly difficult as just one member to participate in the public dialogue. On the one hand we're giving out money for what seemed to be in many cases less deserving applications while on the other we must all stand and watch bed closures and significant moves made, in the social policy field in particular, at a time when there is every reason to believe more moneys are required in many of those areas. I hope that what happened with the new federal lottery money is some small indication that we now have in the social policy field of this government a sense of where the public wants the priorities set. I can only hope that in the course of the coming months we will see more of the same.

As well, I was impressed by some of the other preventive health measures which the



minister announced in his introduction this afternoon. I, like everyone in this room I think, can agree we want to see some significant steps taken in the areas of poison control and in the areas of better nutritional availability within our high schools and elementary schools in particular. Those are some of the things that our select committee of a year ago directed his attention to. I would only encourage a strong and vigorous proposal and policy in those areas. I'm glad to hear that Peterborough has some kind of poison control centre and that others will be receiving the same kind of assistance.

**Hon. Mr. Timbrell:** It is a poison control program, which is a pilot for the province.

**Mr. Conway:** Well and good.

I still do not detect from the minister much more than an ad hoc approach to public policy formation in this social policy field. I get the impression of a continually diligent, hardworking and much engaged minister travelling from one end of this province to the other, throwing a lot of short-term money and a lot of short-term solutions at serious, long-term structural problems. I do hope that in the course of these estimates this year we can debate, with the new deputy minister in our presence, the present policy plans this government has for this very crucial part of government activity.

[3:45]

It is not clear to me where this ministry and this government are going in health care. There does not seem to be any clear signal to those in the health-care industry what the government intends and wants to do. I think it is incumbent upon this debate and certainly upon the minister and his senior officials—who are here in legion; they are all interested, I am sure, in what they intend for the province. Yet it seems to me in my time, that if one were to look back upon the activities of this government in the social policy field as it relates to health in the 1970s, there is not very much of significance insofar as clear and discernible policy direction is concerned. Leadership is required. People in the community and people in the industry expect it and they want it. I think I speak for many of them when I say on their behalf that the absence of it is regrettable, leading to a malaise in the industry and in the quality of care that should be addressed as soon as possible.

In other words, I did not hear today from you any overall comprehensive statement, now almost in the third year of your being in charge of this ministry, about what sort

of goals you and your new deputy minister have. I didn't hear from you any particular reason as to why this particular gentleman was brought on at a time when your ministry was experiencing a critical reassessment of its financial position, if nothing else.

There are those of us who have said that Mr. Timbrell is determined to take Health into a far greater political form. Listening to the debate of a few moments ago, there is no reason to believe that that is any less true now than when it was said by me and others some time ago. If that is the case, what are the kinds of political decisions and who are the kinds of political personnel that you have brought around you to make a mark in Health policy? If it's there, it's not too apparent. I would, for one, like to hear some of it and I would serve some notice now that before these 10 hours expire that I'd like to hear from the new deputy minister as to what his views are and what kinds of attitudes he can be expected to bring and to support.

Many of us recall the controversies in which the previous deputy minister was engaged; the controversies with which he was associated; the reasons, public and private, as to why he might have been promoted to the lofty position of deputy in the Provincial Secretariat for Social Development. I suspect that there are some major efforts at internal reorganization. I'd like to know about them if, in fact, they are going on and the sorts of qualities and the kinds of policies that are at the bottom and at the heart of these issues.

I want to reiterate my concern, which I've stated before, about what has happened over the course of the last few years in the public hospital sector in this province. This summer, I did not have the opportunity, as other members might have had, to travel the province from one end to the other to ascertain the most recent state of the art in the hospital sector. I have, nonetheless, been involved parenthetically with some and I certainly feel they are delighted at the new moneys that have been made available, but certainly much more will be required to deal with many of their operating problems with inflation running this year at almost a double-digit rate. They are looking forward to 1980 with a great deal of concern.

I would be interested to know whether or not there are going to be any creative new financial measures entered into to alleviate the burdens to which the leader of the third party and others—and I'll use his reference, if that's the one to which you took such



strong exception—have legitimately directed your attention. There are problems in his big sprawling system which you and 36 years of your predecessors have built. They are real problems; they are problems that are cutting to the bone. We would do a disservice if we did not recognize them. It is easy for us all to cast about platitudinous praise for all the wonderful things you have done in our name, but you are spending by your most recent account almost \$4 billion of the taxpayers' money.

**Hon. Mr. Timbrell:** More than that.

**Mr. Conway:** For \$4.1 billion or whatever it is, I would hope that—

**Hon. Mr. Timbrell:** It is close to \$11 million a day or \$4.2 billion a year.

**Mr. Breagh:** It's growing daily.

**Mr. Conway:** —that the taxpayers in Frontenac-Addington, in Windsor-Walkerville and elsewhere can be able to see some real progress and some real quality. For a lot of those people, that vision is somewhat blurred in many cases. We certainly expect value for money, and I am not so sure that significant improvements cannot yet be made.

I just wanted to address myself to the rather theatrical objection which you registered earlier this afternoon at the fact that we perhaps were not highlighting the many great things done in our name in health care.

I certainly expect that the leader of the government and his friend the Minister of Health—spending, as they do in this particular case, more than \$3.5 million on information services and a few more million elsewhere on analysis and planning—will be able to get the good message out about all the wonderful things they are doing for the 8.4 million Ontarians.

It's for us, as responsible legislators in this forum, to see whether or not value for money is being obtained, and the questions which I and my colleagues will be raising in the next four days will primarily concern themselves with that.

You mentioned the select committee; I want to talk about the select committee for a moment. You did so marvellously well in drawing to our attention the recommendations which the select committee, of which I was happy to have been a member, made with regard to chronic care. As controversial as those recommendations were—and certainly I have heard from everyone in that connection about the problems in putting that sort of incentive into this system to correct problems that were widely identified for us—the

recommendation made in that report reads as follows: "The committee recommends that moderate per diem charges be imposed upon chronic-care patients in hospitals so as to equalize the financial burden to those in chronic-care hospitals and nursing homes."

One could argue that your choice of a moderate per diem would not have been my choice. In fact, I would argue that you certainly did not choose what would be a moderate per diem, in my view. But in terms of the essential policy, I still stand by it and unashamedly so.

I want to talk about some of the other things that you have carefully avoided in your discussion now and earlier about the select committee's recommendations. I want to talk about three in particular. I still think the average Ontarian finds it anomalous, to say the least, that in a province of about 8.4 million people we have an OHIP data base that offers about 12.2, 12.4, or 12.5 million people, or significantly more people in the data bank than are registered as being people in this province.

**Hon. Mr. Timbrell:** No. That problem has been corrected.

**Mr. Conway:** I wanted to talk about that correction; if, in fact, you have made it, I want to hear about it as soon as I can. I want to know what you have done about accepting the recommendation of the select committee, and of a whole lot of other committees, about cleaning up the data base in OHIP so that we can get some clear idea of who is in the system and what's going on within the system.

I am delighted to hear that you have finally made a decision. I guess there is a big, weighty press release down in my office announcing a heroic program in this connection that I have missed, but I'll go back at the appropriate hour—

**Hon. Mr. Timbrell:** We forgot to put it out.

**Mr. Conway:** You forgot to put it out? Well it is interesting that you forgot to put that out. So I can accept now that the recommendation concerning individual enrolment for the health plan in this province has been largely agreed to and that the civil libertarian arguments have been incorporated in your new policy initiative. That's fine; we'll await your press release or your—

**Hon. Mr. Timbrell:** I'll be glad to discuss that, and either the assistant deputy minister for finance and administration or the acting general manager of OHIP can discuss that with you. We anticipate many more changes, of course, once we have the final recommenda-

tions from Mr. Justice Krever, but the problem to which you allude, which was first brought to public attention by the provincial auditor about three years ago has in fact been largely corrected.

**Mr. Conway:** I want to serve notice that I await with bated breath the arrival of your minions to tell me just how this correction is going to be implemented. I am not quite anxious to have another royal commission stood in the way of some sort of new departure on the government's behalf. I am delighted to leave it there, knowing you have agreed entirely to that long overdue change.

One of the other things that the select committee talks about, and curious by its absence in your remarks today, is the question of manpower substitution. We all know what the problems in the medical sector are. My colleague from Oshawa has pointed out, and you have taken up, the question of medical operations; the numbers, the levels of remuneration, the opting in and the opting out, whatever. But what is the government doing with respect to legitimate and meaningful manpower policy, particularly in regard to substituting high-priced medical practitioners, who may not be required for all the services that they are presently engaged in?

The select committee, among others, directs your attention to the programs developed at McMaster University, and elsewhere contemplated. What have you done about carrying forward the program that was developed at McMaster?

What have you got to say today, to nurse practitioners out in Ontario, waiting for the call to do something that might relate to the training they receive? What have you to say to communities where doctors may not be required in the numbers where they are presently in place, but rather nurse practitioners or other health-care professionals would more adequately than not serve the needs of the community? What has this government got to say about meaningful manpower substitution at a time when the medical sector is creating a great deal of concern for one and all?

What have you done in that particular connection about, again, programs in geriatrics, since we all know that the aging population is one that is going to change the nature of health-care delivery and, in fact, is already doing so: but is likely to do so at a much increased rate over the last years of this century?

I remember again, in the select committee last year, being told by more than a few

people that as late as 1978 we were faced with the clear and undeniable demographic picture for the next generation; and not one school, not one chair of gerontological medicine had yet been introduced in this province. I hope you have got an announcement to tell me that that has changed, and indeed—

**Hon. Mr. Timbrell:** Seven months ago, with the \$1 million from the Provincial lottery for the establishment of an institute of gerontology, yes.

**Mr. Conway:** Yes, well, I want to hear more about that institute. I well remember the press release. I want to see—

**Hon. Mr. Timbrell:** And at the same time as the million dollars from the lottery for the institute on nutrition.

**Mr. Conway:** That's right. It's one thing to have—

**Mr. Breough:** What would happen if we ever outlawed the numbers racket in Ontario?

**Mr. Conway:** —the press releases, and we have just already been told of one that is on its way, but I want to see some fleshed out policy. It's one thing to throw a million dollars at some poor institution, but it is another thing to have some kind of place and some kind of priority for that particular option within the system.

I want to talk about the financing mechanism, recognizing as we found out only too painfully two years ago you as Minister of Health can sometimes sit in the overall scheme of things in the formation of public policy in this cabinet. As I recall, Darcy McKeough did not seem to have paid a great deal of attention to advice offered, such as it was, by the Ontario Ministry of Health, under your hand, in the OHIP matter of 18 months ago.

But your colleague and your predecessor, Mr. Frank Miller, now the Treasurer, in his budget of 1979 addressed himself as only Treasurers in this province do, with troublesome finance questions. He produced a budget paper D dealing with the financing of OHIP in this province and suggested a way in which we might deal with the very, very difficult matter—the hundreds of thousands of people in this province whose entitlement to assistance within the health-care sector is not being fulfilled, because of reasons that we don't need to go into here at this particular point in time.

I didn't hear in your statement any particular comment as to how you view the very troublesome questions of premium assistance, since it was a troublesome and



serious matter of concern for members of the select committee. A strong recommendation was made there, and picked up in some regard in your colleague's budget of March or April of this particular year, pointing out the tragic fact that probably 400,000 to 500,000 Ontarians are not getting the kind of assistance to which they are entitled.

The figures are at best loose and random because, as we found out with the government a year ago, they don't have the foggiest notion of who is in and who is out with respect to premium assistance.

I wonder if the Ministry of Health, and you as minister, have any views with respect to this policy paper, since the mandarins, the Treasury, must now already be planning the inputs for that much anticipated budget in 1980. What is the view of the Minister of Health with regard to budget paper D, recognizing that it is not an exclusively health issue, but one that relates very directly to health care in this province? I'd be interested, some time before these hearings are over, to hear what the honourable minister has to say about budget paper D. [4:00]

I'd be interested also to hear whether or not he's had any time to reflect upon the issues raised there and whether or not he has offered any direct advice outside of cabinet. I would never expect to intervene in the inner sanctum of that very sacred body, but I'd like to know whether he has ever made a formal recommendation about that particular policy suggestion, remembering again of last spring's encounter that hardly a policy paper of any note was generated here or elsewhere.

I'm glad to see the same treatment being accorded the press conference this morning without the most thorough review being offered, line by line, in the Ministry of Health. I know and I appreciate the care with which the minister scrutinizes the activities of all without his purview and I'm wondering whether or not that relates to budget paper D and whether or not there's been any in-depth analysis of its offerings and how he views its potential. So much for the select committee.

I don't think it would be appropriate to avoid the next topic which is of great concern I think to most members in this particular assembly, and that, of course, is the great question of medicare.

I followed the minister's activity with much interest this past summer. It has been more low profile on the province-wide and national level than I might like to have seen in this particular regard. I am sure that in

Don Mills and in Sydenham and in Ilderton and all the wonderful places of Ontario he has been present carrying the good news, but I've not seen a great deal of his on-going view with respect to the integrity of medicare as a public policy. In fact, I have to search through all of George Boddington's speeches and then some to find a fully documented statement of the minister's views with respect to medicare.

I don't ever recall Dennis R. Timbrell, Minister of Health, standing up on a soapbox in Don Mills or elsewhere—and I may indeed stand corrected and his friends can give me the speech or speeches—but I haven't, over the course of the recent weeks, read a speech from Dennis Timbrell which says, "Here I stand on the question of medicare. These are the inalienable principles and rights to which I want all people in this province subjected insofar as this policy is concerned and I want everyone to know of it." Surprisingly and perhaps strangely silent he has been, it seems to me, in reiterating his views with respect to medicare.

Some of us given to some cynicism in the political field might fall back on the sense that this is a government which maintains the old Robarts antipathy to what was brought down from Ottawa in those halcyon days of the 1960s, that there really is no great or intermediate ideological commitment from—

**Hon. Mr. Timbrell:** That was when your colleague was running to defeat that—

**Mr. Conway:** —Dennis Timbrell or others to what it is medicare stands for.

And now that Toryism is rampant in the land—

**Mr. Breaugh:** That's another disease that should be prevented.

**Mr. Conway:** —and now that his friends are in Ottawa, and indeed, his colleague from Rosedale—not far from Don Mills, I'm told—is in charge of all federal health policy, Heward Graffey having been sent elsewhere, I fully expect to hear from him a ringing defence of medicare.

I'm going to be more specific. His colleague, Mr. Crombie, struck a federal review to be headed by Mr. Justice Emmett Hall; as I recall, a review that would assess how the principles that the federal government put forward some years ago have weathered the storm of 10 years.

**Hon. Mr. Timbrell:** Eleven.

**Mr. Conway:** Eleven years. Dennis, you're so precise. I'm wondering and I'm curious, is the Ontario Minister of Health contemplat-



ing a presentation to his federal colleagues' commission in this regard?

Is Ontario going to stand up and say, "We believe the program and the principles of the Medicare Act, 1966, are as valid today as they were then and we assert our unequivocal support for each and every one of those"? Or are Dennis Timbrell and his colleagues in the Ontario cabinet going to shy away from participation in that particular review and maintain what I still believe is an unacceptably low profile in the face of special interest whose principal concern seems to be the dismantling of medicare? If you have been vocal, if you have been making ringing declarations, I'm very interested to hear them and to have produced in front of me all the evidence.

I want to be anecdotal for a minute because one of the great problems the average member has with this question of opting out is to relate it to an individual constituency experience. I must say, unlike other members, I did not have an early encounter in that connection. I represent, I'm sure as all members know, a rural eastern Ontario constituency.

**Mr. Kerrio:** What riding is it?

**Mr. Conway:** The great constituency of Renfrew North.

**Mr. Kerrio:** I see.

**Mr. Conway:** Where the air is pure and the people purer still.

Interjection.

**Mr. Acting Chairman:** The air is not so pure.

**Mr. Conway:** That's the dividing line.

You see, the great problem with opting out is its threat to one of the principles of medicare. Of course, you must understand there are some of us who feel the principle at stake is universal access on uniform terms and it is the uniformity of those terms that is so clearly threatened by the opting out. As someone from the other row chimed in earlier, "Your figures don't really mean too much in those communities where the opting out has reached very significant proportions."

The difficulty for the average member, and indeed, the average citizen, is to understand how this system really changes things in the overall plan. Most people, unfortunately, are prone to think user charges or opting out or balance billing is kind of healthy. They feel you should pay something for going to see a doctor, medicare notwithstanding, because it's only going to be \$2 or \$1.50 or \$3, or some nominal

amount. All of us have had, I think, an increasing experience with those painful constituency inquiries and I've had my share. I'm going to use just one example.

Not very long ago I was called to a very small community in my constituency called Whitney, which I believe you know is a border point on Algonquin Provincial Park. It is a long way from where I live in Pembroke and a long way from a lot of the principal communities in this province. There, a senior citizen, a woman of probably 68 years of age, called me with a particular problem. One day when I was coming back to Toronto I dropped in to see what that problem was.

She was sent by her local physician to a Toronto specialist for major knee surgery. She underwent surgery in a Toronto hospital and was very pleased with the outcome and felt it was particularly worthwhile, and was well on the way to good health again. But she was a little puzzled as to why the doctor, in advance of her arrival in Toronto, had asked for a \$700 pre-paid account.

**Hon. Mr. Timbrell:** I can tell you right now that is specifically considered professional misconduct under the Health Disciplines Act and that lady should be filing a complaint with the College of Physicians and Surgeons.

**Mr. Conway:** That may be so, but I just want to—

**An hon. member:** A down payment for health care. Let the buyer beware.

**Hon. Mr. Timbrell:** No, I just want to interject right now that is not considered to be professional conduct. That is specifically covered under the Health Disciplines Act and identified as professional misconduct. You should be informing that lady, with all due respect, to file a complaint with the College of Physicians and Surgeons with all due haste.

**Mr. Conway:** I have already done some of that, I want to tell the story because we can listen to your response, but I know my good colleague from Prescott and Russell (Mr. Belanger) will appreciate that out there a long way from Toronto the kinds of answers that might be bandied about and around this room don't mean a great deal to a 68-year-old woman who's faced with the need for serious surgery, is sent to Toronto by a very close community physician, and is confronted with the request, as I was told—and I'm only repeating what I was told—for a \$700 cheque in prepayment of her account for surgery that was offered in, I believe, late June or early July.

In September, she called me, not on the questions you have raised about whether or not misconduct was involved, but as to whether or not she'd ever hear from OHIP about the payment of the account so far as it went in this connection. As of about three months after the fact—it was at least three months, a little over three months—that woman had still not heard from OHIP.

**Hon. Mr. Timbrell:** Did you phone them?

**Mr. Conway:** We phoned them, and I understand the process has now been put to work.

**Hon. Mr. Timbrell:** Good.

**Mr. Conway:** We might say good and well. But is it good and well for a woman who is 250 miles from here, who has seen \$700 of her money taken away and a considerable amount of time pass before she's even heard from her insuring agency as to the remuneration they're going to offer? As we all unhappily know, it's probably going to leave a significant shortfall of anywhere from \$150 to \$200, if not more; I can't quote the figures.

There, as I know every member in this assembly can offer you, is the real challenge to medicare. If for no other reason, I want you and your cabinet colleagues to stand up for that woman and to speak your piece in defence of a system that will not put those people through that kind of tyranny, which is what I believe it to be.

I think it is incumbent upon you, as a major leadership figure in the social policy field of this government, to say that is intolerable and unacceptable and that some system of redress will be offered to that woman and everyone in her position. I can't make that any clearer than I hope I have right now.

**Hon. Mr. Timbrell:** I don't think it needs to be any clearer. I totally agree with the member, that's unacceptable; it has always been unacceptable and it always will be unacceptable. I would hope, if you haven't already advised your constituent to file a complaint with the College of Physicians and Surgeons, that you would call her tonight and so advise her. From the beginning of time, so to speak, a call for prepayment is considered to be professional misconduct in this province.

As regards the processing of claims, our turnaround is about six weeks.

**Mr. Conway:** You've missed the point.

**Hon. Mr. Timbrell:** No, I haven't missed the point.

**Mr. Conway:** The point I am directing to you as Minister of Health is, what about the

differential charge, which in this case is going to be of the order of \$100 to \$200? That's the issue at stake, the issue I am directing to your attention now. That is an absolute and fundamental challenge to the medical program that we know as medicare. That's the matter I want some redress for, notwithstanding the other legitimate questions you have properly raised in this connection.

For you as Minister of Health, as the man charged with dealing with and protect medicare, the question is, what recourse does that woman have to the fact that she now faces a differential charge of a very significant amount in her category?

**Hon. Mr. Timbrell:** I will be dealing with that in the next few days, but I would be interested in the member's views on how that should be redressed. I've never heard a definitive statement from his party on that, and I'd be very interested in his solution.

**Mr. Conway:** You shall hear what you shall hear, my good friend. I'm telling you that as someone who purports to be the Minister of Health, as someone who purports to stand for this government's social commitments in the health-care field, it is infinitely more important that the people of Ontario, in north Renfrew and elsewhere, understand where you stand and where you stand as a government, charged with proposing measures in the public interest to deal with these kinds of immediate problems.

**Hon. Mr. Timbrell:** I quite agree. I think it's important too that those same people understand where those who would be the government, if they had their way, would differ.

**Mr. Conway:** A debate will ensue, my good minister, in which you shall be appraised of some of our suggestions.

**Hon. Mr. Timbrell:** I look forward to that. [4:15]

**Mr. Conway:** It is drawing to a point where I wish to change subjects. This isn't going to be very pleasant either, because if there is an area in which I think this government needs its collective rear-end kicked halfway to Cornwall, it is in the area to which I'm now going to direct your attention.

I was particularly interested earlier today when I heard of all the wonderful things that are going on in preventive health care, that great motherhood commitment around which we all rally. The minister can announce today that there's a poison program here and there's a nutritional program there and I'll tell you Mr. Braeugh, myself and everyone else



around here will applaud. It is wonderful stuff.

But there's another issue in the preventive health care field which has been—and I would not use the words that come to mind—ignored tragically. That is one which has been raised here before and I drew your attention to it this spring. It grows again out of my experiences as a member of the Ontario select committee on nuclear safety this summer. It deals with public health and the hazards of radiation exposure.

I almost went over to the Hepburn Block and did something nasty when I read at home not very long ago an account in the *Toronto Globe and Mail*. Correct me if I'm wrong because I want from you a statement of exactly what you, your predecessors, your bureaucrats, all your commissions, studies and consultants have done about it. As I understand it, four years after the fact of a clear public hazard being identified in the Port Hope area nothing has been done by either the federal or the Ontario governments to study the long-term effects of radiation hazards as they are presenting themselves to the people in that area.

I want to know exactly what your position is on the so-called radiation question that has been raised with respect to Port Hope. I want to know, more specifically, what you intend to do with your federal colleague about monitoring the kinds of hazards which well-meaning citizens, professional and otherwise, have identified in that area. You're part of a government and I'm part of the group which supports a commitment to nuclear energy. But that commitment isn't going to mean very much if we ignore the kinds of health hazards that have been long associated with the front and back end of the nuclear fuel cycle.

We've had clear evidence that there is at least the beginnings of a serious problem in the Port Hope area. I am led to believe that the Ontario government and the former federal Liberal government in Ottawa have done precious little with respect to committing dollars and resources to ascertain exactly what is the threat to the health and safety of those people living in that part of Northumberland county and, I dare say, to those people who have been exposed in a similar way at Elliot Lake, at Bancroft and elsewhere. I want to hear from you before we leave these estimates hearings exactly what you've done since that problem reared its head in 1975-76 and what you propose to do with respect to the future.

I'll end this short opening comment with another point in that area. Again I have to

put this in the context of what we've been listening to in the great public debate with regard to nuclear safety where the issue is low-level radiation and where the issue is about what happens when a hydro worker is exposed to a four- or a five- or a six-rem blast up at Pickering or Bruce or elsewhere over the course of a year. A great and justifiable to-do is made about that. I was sitting there day after day this summer thinking about our friend Mr. Taylor's report this spring, which indicates that if you really have a concern about radiation you should probably not spend your time in the first instance looking at Ontario nuclear reactors, but you should start scouring the public hospitals of this province and other health-care industries, if the Taylor report can be believed in any way.

**Hon. Mr. Timbrell:** What does he say? Tell me what you think he says.

**Mr. Conway:** I'm reading, for example, from an essay, a contribution which he made to the March 1979 *Journal of Canadian Radiologists* in which he makes the comment—let me read the first part of the summary: "X-ray exposures to patients were measured in 30 rooms in Toronto hospitals. For a given procedure the total exposure for a satisfactory examination differed from one room to another by as much as a factor of 30, in itself something about which to be very concerned."

**Hon. Mr. Timbrell:** What does he attribute that to?

**Mr. Conway:** Skin exposures reaching 90 rems.

**Hon. Mr. Timbrell:** Go on.

**Mr. Conway:** No, no, I want to stop right there.

**Hon. Mr. Timbrell:** What does he attribute it to?

**Mr. Conway:** Just hold on; 90 rem. Do you realize that if you received 90 rem at the Bruce nuclear generating station all hell would break loose—as it should?

**Hon. Mr. Timbrell:** Mr. Chairman, I will be glad to get into this in some detail on Monday but the honourable member is taking diagnostic radiology and trying to make an exact analogy between that and an industrial—

**Mr. Conway:** Exactly. I have done exactly that with a premeditation for which I do not apologize. What I want you to tell me—

**Hon. Mr. Timbrell:** Read on. I want him to read the whole thing and talk about what he attributes the difficulty to. Nobody is



questioning the problem, but what does he attribute it to?

**Mr. Conway:** Well, among other things, he comments upon deficient equipment, poor training and rather shoddy inspection.

**Hon. Mr. Timbrell:** Oh, no, not in that paper.

**Mr. Conway:** Well, I am attributing it to—

**Hon. Mr. Timbrell:** Well, don't attribute it to Mr. Taylor.

**Mr. Conway:** —very shoddy inspection. And I dare say that—

**Hon. Mr. Timbrell:** Nobody has found that.

**Mr. Conway:** —within his documentation—

**Hon. Mr. Timbrell:** Mr. Chairman, with respect, I think I have to stand up for my staff. Nobody—Johns, Taylor, or Hobbs—at the radiological research laboratories has come to those conclusions—people who know what they are talking about.

**Mr. Conway:** Well, let me ask you a rhetorical question. Are you denying that there is the differential of 30 times? Are you denying that for these various episodes a maximum amount of 90 rems can occur in this province?

**Hon. Mr. Timbrell:** Absolutely not, Mr. Chairman.

**Mr. Conway:** Well I am asking—

**Hon. Mr. Timbrell:** But what I am asking the member to do is to read the whole paper and look at what Taylor found to be the root cause. What he is going to find is the need to educate both radiologists and radiological technicians in more up-to-date information on how to use diagnostic radiology—to use

lower levels of exposure to get as good pictures for diagnosis.

**Mr. Conway:** Undeniable. I cited that in the general reference of training, et cetera. I am asking the honourable minister what he is doing to protect the public of Ontario from these very serious public health hazards. I have a series of questions in that connection which I want answered.

Mr. Chairman, on that quiet and conciliatory note I rest my general opening summary, anticipating with much interest the response of the minister to those and other questions which my colleagues in the official opposition consider serious in the public debate of health-care policy in Ontario.

**Hon. Mr. Timbrell:** Mr. Chairman, Mr. Boddington of my staff would like to know who wrote the honourable member's speech. He wanted to confer afterwards on—

**Mr. Breagh:** Professional jealousy erupts its ugly head.

**Mr. Conway:** Mr. Minister, on that conciliatory ending, do you have any comments?

**Hon. Mr. Timbrell:** No, Mr. Chairman. I will be glad to respond next week point by point. Certainly the last question the honourable member raises is a very important one, and one on which very concrete steps have been taken over the last couple of years. I am very anxious to discuss all of those issues which he has raised next week.

**Mr. Chairman:** Given the earlier agreement by all committee members, I now declare this meeting adjourned.

The committee adjourned at 4:25 p.m.

## CONTENTS

---

Wednesday, October 10, 1979

Opening statements: Mr. Timbrell, Mr. Conway .....	S-825
Adjournment .....	S-847

## SPEAKERS IN THIS ISSUE

---

Breaugh, M. (Oshawa NDP)  
Conway, S. (Renfrew North L)  
Cooke, D. (Windsor-Riverside NDP)  
Johnston, R. F. (Scarborough West NDP)  
Kerrio, V. (Niagara Falls L)  
McClellan, R. (Bellwoods NDP)  
Ramsay, R. H. (Sault Ste Marie PC)  
Ruston, R. F. (Essex North L)  
Sweeney, J.; Acting Chairman (Kitchener-Wilmot L)  
Timbrell, Hon. D. R.; Minister of Health (Don Mills PC)









S-30

# Legislature of Ontario Debates

## Official Report (Hansard) Daily Edition

### **Social Development Committee**

Estimates, Ministry of Health

**Third Session, 31st Parliament**

Monday, October 15, 1979

Speaker: Honourable John E. Stokes

Clerk: Roderick Lewis, QC

## CONTENTS

---

Contents of the proceedings reported in this issue of Hansard appears at the back, together with an alphabetical list of the speakers taking part.

Reference to a cumulative index of previous issues can be obtained by calling the Hansard Reporting Service indexing staff at (416) 965-2159.

Hansard subscription price is \$15.00 per session, from: Sessional Subscription Service, Printing Services Branch, Ministry of Government Services, 9th Floor, Ferguson Block, Parliament Buildings, Toronto M7A 1N3. Phone 965-2238.

Published by the Legislature of the Province of Ontario.  
Editor of Debates: Peter Brannan.



## LEGISLATURE OF ONTARIO

MONDAY, OCTOBER 15, 1979

The committee met at 3:48 p.m. in committee room 2.

### ESTIMATES, MINISTRY OF HEALTH (continued)

**Mr. Acting Chairman:** Gentlemen, we'll call the meeting to order. We adjourned at vote 3201 and Mr. Breaugh is first.

**Mr. Breaugh:** The annual leadoff for a critic, in traditional terms, is to make a kind of an assessment of recent problems, the state of the art, and I'd like to do that, because I think that in all of the provision of medical care—and it's such a complicated instrument to accomplish such a simple idea of keeping people healthy—there are so many ways for things to go awry. It strikes me that today in Ontario most of them have gone awry.

One of the books I read over the summer is a book by a man named Malcolm Taylor. It's called *Health Insurance and Canadian Public Policy*. It's a rather incisive description of how we came to what some of us would call medicare in Canada. Others would avoid the use of that particular word and choose a different term. It establishes the role that different politicians at different levels of government play from time to time in seeing that some form of medical care is provided through governments at many levels in Canada today.

It establishes some of the major players in that scenario, people like Tommy Douglas in Saskatchewan, and the irony of one of our poorest provinces, with probably the most deficient tax base, one of the largest per capita debts in the nation, going it alone, establishing for itself a medical care program in the early 1940s that was really the envy of the nation. It spurred several other provinces to go on their own. This province hesitated in that process and became involved at a later date.

It also establishes pretty clearly that for Saskatchewan at least, and for a number of other provinces I suspect, the major thrust really is that you need finances. For Saskatchewan it meant going to resources, taking the taxation out of the resource sector from five per cent to 25 per cent to finance the

system, and I think recognizing some rather unique problems that Saskatchewan faced.

It did not have the kind of medical staff system. There wasn't a medical establishment in Saskatchewan as there was in Ontario or Quebec. Medical schools weren't as prevalent there. It wasn't the place where there was a large urban complex to be served, to provide the kind of developmental techniques, the academic surroundings, the amount of money, and distribution on a concentrated per-capita basis that would allow you to get into very fancy forms of medicine.

So in Saskatchewan there was almost a just-plain-folks atmosphere to it. There was a need to provide medical care for your people and if you really wanted to do it you could, but you had to move to using your resource sector to provide the financial backing.

They had to go to recruitment programs for physicians. They had to develop municipal doctor programs. They had to develop advisory programs on a regional basis. They had to build hospitals. In that one province, the pioneer of medicare in Canada, you really had to start from scratch so to speak, and particularly when compared to other more wealthy provinces like Ontario there was a much further piece to go.

It analyses fairly carefully, too, the roles of those who were in favour of some kind of medical care insurance. It reaffirmed in my own mind the present position, for example, of the Canadian Medical Association, being somewhat different from their original position. In the 1930s, I think we sometimes forget, it was the CMA which was rather in the forefront of bringing to health care in Canada some kind of public insurance.

You could argue that the CMA was, in essence, looking after its own doctors' needs, because in the 1930s, in the middle of a depression, there weren't that many people who could afford to pay their doctor. But none the less, the medical association, the hospital association, the trade union movement, everybody was saying in the 1930s: "You cannot allow this current situation to continue, you must go to some kind of medicare. You can soften that; you can call it a health insurance plan, you can establish priorities, the obvious one being to see that you can provide good

care in a hospital setting as your first piece of business." Most governments respond in that way. You can also clearly establish in here that identification of problems didn't change very much, either, through the years.

In the 1940s, once a hospitalization program had been established in, I think, two of the provinces, we moved on to a different form of care, providing the other major focal point for delivery, which is looking at the doctor, how the doctor is financed, how the doctor provides the service, where that might happen and what the setting is.

Again, I see some substantive changes in the approach of medical associations to the whole matter of providing medical care at public expense in whole or in part; the variety of schemes that were proposed and analysed at that time. I notice too in the late 1950s, when there was a good deal of work done at the federal level establishing what the needs were, the needs established at that time were not much different from the needs established here in Ontario some 20 years later.

Chronic care is a problem. Provision of care in outlying areas is a problem. Some distribution of a sameness of care in hospitals remained a problem. Funding of hospitals was a problem. Training of new doctors was a problem. The rather difficult question of who provides the care: Is that a full-fledged physician? Is it a nurse? Is it an RNA? Is it a nurse practitioner? It seems that in 20 years of trying to put some form of medicare into place in the nation we've avoided dealing with the issues that were identified initially.

The political process probably, in the Canadian experience, didn't serve us too well, but did manage to accomplish in Canada what has never been accomplished in the richest nation in the world, and that is some form of publicly-funded medical care. We use a variation of a medicare scheme that is different from that which has developed throughout many countries in Europe, and perhaps that's the trick of the trade, to provide in whatever social or health care policy field we're working something which is uniquely Canadian, that is different from medicare in Britain, or in the Scandinavian countries, or in Germany. I think the Canadian experience is different from that of those countries, our resources are different and our approach to life is different.

So we've accomplished something which is significant, and that is, we have in place a system. Does the system work? Yes, it does. In certain ways it works extremely well. I think it's reasonable to say that in some very

highly technical and specialized fields, Canadian medicine is without par in the world. It seems rather strange that we set out to provide basic medical care and that's where we're still having the problem, but in the areas of specialization and new technology we're among the best in the world.

How did we get to that point without solving the initial problems of basic care? I think that is the question that ought to be answered in some form here. I sense, in my visits to hospitals and to doctors and, most of all, to patients, that we haven't accomplished that basic goal yet. We have in some places; in others, care is actually not what it should be by anybody's standards, and that's the problem. Trying to determine that level of care is extremely difficult as well. The minister knows full well that there are all kinds of people analysing whether a financial restraint program on the part of the government affects care, and the difficulty of course is that you're left with the generality which everyone admits, "Yes, it does affect the level of care, but we're not prepared to say, at least publicly, how much."

I think that is another flaw that has evolved in the Canadian system, that public scrutiny of health care is almost a no-no. One can get all kinds of numbers from a variety of sources—from the federal government, from all the provinces—but scrutiny of the system is not an accepted fact just yet. Certainly not by the public. The public is assessed a rather healthy amount of taxation in a wide variety of forms. For my own family, in trying to estimate how much money we paid, publicly and privately, to provide health care to my family is pretty difficult. You need a combination of things.

We paid federal taxes. Part of that money went to health care. We paid provincial taxes. Part of that money went to health care. We paid municipal property taxes. In an indirect way, part of those funds go to health care. We have private plans. We have public plans. We pay a premium. We donate to several groups of people. We donate to specific institutions. So trying to answer, "How much did Mike Breaugh and his family pay out last year for health services?" is not easy.

My own little recollection of one-and-a-half wage earners, and four people, is that we probably put in excess of \$2,000 into the system through all of those different ways, and we used it last year four times.

I think we're quite happy, as a family, to pay that kind of money, for several reasons. The first is, because of the nature of our family, maybe social. We're quite happy to say that we who have the ability to earn



money, put money into a system that looks after those who do not have that ability. That's fair.

[4:00]

We're also, I think, in the back of our minds saying that we're quite prepared to do that now, and probably for the rest of our lives, on the chance that, to be a little more specific about it, on the reality that at some point in time we will need that system far more than we have to date. It might be my family who will have a member going into the hospital for two months, three months, whatever. We look at the reality of the American experience, and we recognize the cost of high-technology medicine these days, and it's a rather good investment for us. If we had a child who was in a neo-natal unit at \$462 a day, it wouldn't take very long to bankrupt the family.

Even if you moved off that rabid free-enterprise American concept and moved to a private scheme or to partial payment, you would still be looking at substantial amounts of money for debts. In other words, you really would be facing, as a reality instead of a theory, long-term debts for an entire family because of illness.

For the most part in Canada today you avoid that. So to that degree, anyway, we can say that our Canadian medicare system works. It's there; it has obvious flaws. In a number of ways this committee in its deliberations during the spring session with several hospital administrators established that the flaws are for real, that they cause very serious problems for the people of Ontario, for those who work in the field, and to those who use the system.

The other serious problem that I see is that we have not yet come up with a device for examination by the public. It seems, in part—to put it perhaps a little more harshly than it should be put—that the system, theoretically, operates for the benefit of the people of Canada—a little more specifically, for patients. But it is difficult to determine that, in examining how the system is funded, how it works, who has approvals, who decides who can provide care, and in what manner.

And can the public get information about the system? That's awkward, at best. There are some mechanisms in place. District health councils are one that come to mind very early on, as being a mechanism for the public at large to make that assessment. One then has to go to the record of district health councils, which is theoretically sound and which is a concept that most of us support,

but which in practice is difficult, performance being spotty, it still being rather new, and we not being terribly sure that the public at large is really represented on those health councils because the public at large does not appoint people to the health councils. In reality, the government of the day does.

I have seen some changes in the formation of health councils and the addition of several people to health councils which in my view have improved that situation somewhat. But as a public agency for finding out information about a health-care system, whether that information be financial or have to do with the level of care, that isn't really a successful mechanism.

Nor, I must admit, is this committee of the Legislature a successful mechanism. In my experience last year we put a number of questions on the Order Paper, some of which required detailed answers, some of which did not. Not many of them have been given answers, let alone satisfactory answers. This points up that when a member of the Legislature has difficulty getting information about something that costs \$4.3 billion a year, there is definitely something wrong. Part of it is complicated by traditions of confidentiality about what we pay individuals within the system.

This province has adopted an attitude which is somewhat different from other provincial governments' about, for example, releasing average incomes for physicians and for specialists. Though we can determine some of that information, we cannot get it all. Certainly there have been occasions in the recent past around here when there was absolute outrage expressed by physicians at the release of amounts paid by the Ontario Health Insurance Plan to particular individuals out there.

So the concept that is widely accepted in other areas—for example, for me and for almost everybody in this room, as a matter of fact, which is a lot of people; civil servants, Hansard staff, the members themselves and the minister himself—it's all just accepted that our salaries, our incomes are a matter of public record, and if you really want to find out how much money Dennis Timbrell makes, you can go some place and find that. We have not established that same criterion for the medical profession. And we have some difficulty in establishing that for hospitals, in terms of actual expenditures, though they all publish an annual report. To my knowledge they do, anyway. So the specifics are what are in question.

In theory one would think, for example, if a hospital in St. Catharines hires an out-



side consulting firm and that is going to cost some initial money, even though there might be long-term savings, that that should be a simple matter of public record, and yet it's not. It's very difficult to get that information. Hospital administrators are reluctant to release that. Why, is an interesting question. It really, in my view, has not much more to do with anything more pertinent than our traditions: there are some things we do and some things we don't do. It's very difficult to change that around. If you look for a logical answer, you might get confused about it all.

This matter of level of care is an ongoing concern of mine. I think that I have tried, and I know a number of members of this House have tried in a variety of ways, to establish how much the level of care has dropped. I think we've arrived at a consensus. The level of care has dropped. But to what degree? We saw administrators before the committee in the spring, some of whom would go that far. They would say, "Yes, the level of care in my hospital has decreased somewhat." But all of them added caveats. All of them were unwilling to admit that in their hospital, the one in which they worked as an administrator or the one in which they worked as a doctor, the level of care was still good, still acceptable. To those who carried the party line a bit further, there was absolutely nothing wrong with it.

That argument, that perspective, has some serious flaws in it. One cannot successfully argue, and of course they don't, that you need more money to run your hospital, unless there's something wrong with it. In other words, if the hospital is getting along just fine over there, why are administrators continuing to press the ministry for more funds, and through their members, this committee, to open up that situation, as we did in the spring, and to have that kind of an investigation?

So there is something wrong out there. The level of care has dropped, in my view. I can't establish direct relationships, as I would like to, and as you could, in several other fields. I don't think we want a body count. But we do want to know that one is being taken out there.

It has been my experience, and I think it's been borne out on more than one occasion now, that there are two levels of reporting going on here. There is one level of hospitals reporting to the public in a very general way, through their annual reports, through their doctors, through public statements made by administrators. At that level,

hospitals are saying to the people of Ontario, "We have a financial problem, and we need some adjustment and some assistance from the minister." I wouldn't take direct credit for this committee, but I think in the work that the committee did in the spring of this year we did establish that there was a real need among a number of hospitals, that the rules of the game didn't apply to everybody as fairly as they should have, and that more money had to be put into the system.

Though I didn't see any direct acknowledgement of it, I did note with some gratification in July that the minister had got another \$65 million to put into the system. I applauded that action at the time, and subsequently found myself taken aback for applauding something, when I went to other hospitals who said, "We heard the announcement all right, but when we called in to find out how you apply for additional funds, we were told, 'Don't bother because those funds are already allotted'."

**Hon. Mr. Timbrell:** Who was told that?

**Mr. Breaugh:** I was.

**Hon. Mr. Timbrell:** At which hospital were you told that?

**Mr. Breaugh:** Windsor Western.

There is something wrong when I'm told there are difficulties in financing the existing hospitals, that in fact there is a need to cut back beds because standards are being overmet in some cases, if that's possible. Yet I see the same minister who, at the beginning of September I think it was, announced he had come up with an additional \$100 million to build new teaching hospitals in five areas. I must admit I was not as well informed as I should have been. I was not aware of a great need for new teaching hospitals.

In particular, to put a perspective and a balance and a set of priorities at work here, how do we justify building new teaching hospital beds, if we can't run the system we now have? Are we talking about building new facilities, as opposed to converting facilities? If the argument is, as I heard it in the spring, that we really don't have too many beds but we've got the wrong kinds and sometimes in the wrong places—specifically, we've got too many active-treatment beds and we need to crank up some chronic-care beds—if that argument applies there to chronic-care patients, does it not apply also to teaching hospitals? I think it probably should.

The awkward problem of assessing that level of care has been addressed in a number of ways by members of this House. One,

and I guess the most dangerous way, is that we all have constituents coming to us now, which I frankly never had before in my experience, either as a legislator or working in the office of someone else who was. I never had patients coming from hospitals with complaints about the level of care that they got. That's true. There's almost a tradition that one complains about the kind of food that is served in cafeterias everywhere, whether it's a courthouse or a hospital. It's true that you always used to run into conflicts between a particular nurse or doctor and a patient. But it's not true, and it is unique, that we are now beginning to get, on a regular basis, people coming in—family members, individuals who were patients in a hospital—complaining about the level of care.

From my point of view as a legislator, that's difficult because I probably have never seen this person before in my life and I'm not a doctor. So for me to make an assessment about the level of care is rather difficult. I wasn't there, in the first instance. So to be fair about it, I have some awkwardness about that. But I also don't have anything else to go by. That's my criterion; that's the source of information that I have.

A number of people who work in hospitals have put to me something that I find rather disturbing. That is, after we have our general discussion about the level of care in their particular hospital unit, I generally put to them that I need something far more specific than their telling me about their complaints about working on the ward. I have heard a great deal about quotas being put on bandages, soap and all kinds of things like that. So I want to know the details of that. I want to see the hospital memos that tell them they can clean this side of the ward today and that side of the ward tomorrow and not to cross back and forth, no matter what. Those seem to me to be not very sensible approaches. They might look good on paper and all of that, but in practice I don't think things ever work out quite that way.

I find an aura of fear among nurses, hospital workers and even in some doctors that exercising their right to speak out on what they see happening, on what they discern as being a very real problem, will cost them their jobs. I find that an unfortunate piece of business. I have suggested in a number of ways that they don't have to identify themselves, but then again it is true that if there are only two nurses working on a ward and one relates a problem that they might be having, however inconsequential that problem might be, it isn't hard for the adminis-

trator of the hospital to identify who blew the whistle.

They do not feel free to speak out about their system. They do in a very general way, with the protection of their nurses' association. The Ontario nurses put out, in newspaper format, about a year and a half ago, a kind of log of problems that they were finding in hospitals. Various unions representing those hospital workers have from time to time put out publications attempting to identify particular problems in particular institutions. They are bound, in many cases, by the conditions under which they are hired about the release of information, the confidentiality of medical records and a respect for the rights and the needs of the patient, and I'm sure that we're all aware that we don't particularly enjoy using someone's name in the House.

On the other hand, you get caught in the crossfire on this. If you don't use the name, if you don't have the specifics on where something happened and what that person's name was, the minister says, "Well, that isn't for real. You can't do that." On the other hand, if you use the person's name and you document when it happened and where it happened, then that's not nice. You shouldn't do that. I might agree with that in theory, but in practice, what else have we got? Where else do we go? So there are some difficulties in there.

To have a free and open discussion about hospitals and the level of care in Ontario is difficult. It isn't easy to document. From a reasonably objective third-party source it's difficult. The minister criticized me the other day for releasing a report that I received from Wellesley because "that wasn't fair."

What I find particularly galling, as every good police officer will tell you, is that to know what's going on is one thing, but to be able to substantiate that and prove it in a court of law is quite another. We don't have to go to court too often, as members of this Legislature—some of us do—

[4:15]

**Hon. Mr. Timbrell:** Some more frequently than others.

**Mr. Breaugh:** —but in practice, we do have to substantiate the things we say, and that is difficult.

I am afraid that two-level system of reporting is at work. The minister, I am sure—because I have now seen some of the information that he gets—gets a far different set of evaluations than we do. I have seen, for example, in one hospital alone, Wellesley, two analyses done by staff there of the effects



of shutting down beds over a two- or three-month period that were far different certainly than what that administrator said to this committee in the spring of this year.

Though they are awkward and though I guess no one in the world has developed a system of reporting on the effects of a restraint program through a hospital system and come out the other end with some specific conclusions, and while no one can, and probably no one wants to either, establish direct relationships between a budget cut or a restraint program or the removal of personnel from a floor and the level of care that is provided to the individual patient, somehow we must come to grips with that. I am afraid I don't see much of an open admission that there is even a problem, let alone much of a solution on the horizon. Those are problems we have presented in the Legislature in various forms.

There are some things that you can't say from kind of a cost point of view. In a number of hospitals I have visited in the last five or six months there has been no question that they are reasonably open about the financial picture, that it isn't difficult to understand you can't take a 4.5 per cent average increase and get as much with that if you are looking at 14 per cent for food and 28 per cent for drugs and 15 to 20 per cent for hospital supplies. If your wage settlements are seven to nine per cent, there is a cost squeeze at work there. So without question it isn't hard to understand that, in financial terms anyway, there is a serious problem. To take it much past that is a little awkward.

It strikes me that hospitals have roughly two alternatives in front of them. One is you can run a deficit. I don't know of anybody who really wants to run a deficit in health care, because you are not too sure of what your alternative funding program might be. I guess the idea is that you run a deficit—Windsor Met was looking at about half a million dollars—and you hope that some source of funding arrives sooner or later—I'm not quite sure what it is—or you cut the staff. The Windsor Western is another hospital in the same town which decided to do that.

A number of administrators have taken the route of, well, we won't really cut staff in terms of paper numbers, but in actual decisions on the wards of who works where and when, numbers have been cut there. I see an increasing trend to move away from full-time staff working regularly in a hospital and making increasing use of part-time staff. That has some good sides and some bad sides to it.

One could argue, and I have heard it argued with some eloquence—for example, in St. Peter's, a chronic-care hospital in Hamilton—that by sending out kind of a large number of part-time staff people to work in the hospital everybody gets as much work as they want two or three days a week, and they weren't able to establish that there were any adverse effects on the patients. In fact, for some of them it was quite good because they got to see different people. In a chronic-care institution it may be possible to do that.

I also talked to another young hospital worker who had applied for a job in a hospital in Hamilton, for seven months in a row. He couldn't get a job, but managed to get 14 straight days of work through a system that is, in that particular situation at the Hamilton Civic, referred to as an on-call system. In other words, you are available for work; the hospital will call you, you go in and work your shift and they'll call you again the next day. You don't belong to the union, you don't get union wages, you don't have seniority rights, you can't file a grievance, but if you are prepared to work that kind of time you can do it; and that's not an unusual phenomenon. I know that same technique, and variations of it, are employed in almost every hospital across the province.

The interesting thing is, if that same labour technique were used in other situations we might be rather upset about it; we might even say it's a violation of the Employment Standards Act in the province of Ontario. I am not sure that we want to get that dramatic about it, but certainly there are problems for people who work in hospitals—the problem of tenure, the problem of representation—and there are a number of unions who are working very hard to see if they can rectify that. It's a slow and awkward process.

Let me move to another generalized area that causes me concern, and that is, we have talked at great length on a number of occasions in this committee of moving to a different approach, a different perspective on health care, that it should be preventive in nature rather than curative, and I see a growing consensus among almost anybody who is even vaguely interested in health care that that's what you should do.

We have all learned how to express ourselves in those terms; we have picked up the jargon; we have all done position papers, and I think most professional groups—nurses, doctors, whomever, certainly the minister has on occasion and my party has—have done discussion papers, green papers, policy positions, all of that kind of material has been



put out to generally support the notion that preventive care is the way to go, and that in long-term costs preventive care is probably cheaper, though that isn't the purpose of the exercise.

The purpose of the exercise may involve curtailing costs somewhat, but basically it's to provide better care; that if you convince people in their 30s and 40s to lose weight, you won't see them when they are 50 and 60 for open-heart surgery—roughly that line. Certainly it's a supportable notion. I have read the releases of the minister, which are standard form on this kind of stuff. They have the right language. Certainly the proposition is a supportable one.

But when I see, for example, with this government in Ontario today, running, through the LCBO, a billion-dollar operation on the sale of alcohol, just through the LCBO; yes, a billion dollars this year will come out of the LCBO. Read the report, Dennis.

Hon. Mr. Timbrell: No.

Mr. Breaugh: You don't have to read it, your staff can read it. That's a million dollars a day. I would be impressed if this minister said—

Hon. Mr. Timbrell: A million dollars a day?

Mr. Breaugh: Do you want to read the annual report while I continue here?

Hon. Mr. Timbrell: Yes.

Mr. Breaugh: I'd be impressed if the minister said, "We will take half of the money the LCBO makes and we'll put that into some kind of a real anti-alcoholism program, or we will reinvest the kind of profits we get from the LCBO and we will do that in a substantive way"; \$990 million from 1978-79 is their gross.

Hon. Mr. Timbrell: Oh, their gross, oh their gross sales.

Mr. Breaugh: That's what I said.

Hon. Mr. Timbrell: Oh no, you said profits, sorry.

Mr. Breaugh: No, I didn't say profits. You have this listening problem.

Hon. Mr. Timbrell: No, I don't.

Mr. Breaugh: It's a billion-dollar business; almost a million dollars a day in profit from the LCBO.

So when I see that the minister is announcing a \$600,000 program, in the first place I am impressed that he has recognized the need, and \$600,000 is not to be sneezed at. That doesn't bother me at all, but to put it in perspective, I am not sure

that there is really a convincing argument put forth by the government that it is really going to go after a preventive program that works.

I am aware of the studies of addiction research in the private sector in a number of industries—GM being one of them—which certainly recognizes the problem that alcoholism causes in the work place and in society as a whole. So we have clearly established the need. I think we have even established some models for care and prevention that are workable. But when I see less than a day's profit going into a program to fight it, then I have to make the judgement in my own mind that that really isn't the very serious kind of approach that I want to see.

When I read that the National Council on Welfare says there are a million women in Canada trying to feed kids on rice and macaroni and bologna because they are living below the poverty line, and I hear the minister address himself to the problem of good nutrition, I am impressed by what he says. But when his response to that is the \$20,000 poster program that will put money back into the schools, I am not as impressed as I started out to be. It's a matter, again, of spending priorities, a matter of perspective. If this government was not prepared to hand to the private sector, in the pulp and paper industry and the automotive industry, grants and loans and whatever in the order of \$100 million—in excess of that actually—I'd be prepared to listen to the problem of restraint in health services. But until they do that as a matter of spending priorities, I can't accept the government's position.

When I listened to the kind of relationship that evolves—this is another thing that, quite frankly, was brought to mind again in reviewing Taylor's book at a time when the other committee responsibility I had was listening to the Ontario Council of Health—I was reminded again of the kind of incestuous relationship, to use John Wilson's term, of people in the health-care field, in the government and in the private sector in Ontario. Because you keep running across the same names, the same people who on one hand at one time ran the private insurance carriers in Ontario then moved to assist rather substantially in the setting up and running of the publicly funded insurance scheme in Ontario. Then you run across the same names as advisers to ministers in various ministries, and then you run across the same names again sitting on the health council.

John Wilson put it rather succinctly in his address before the procedural affairs committee, when we were reviewing agencies. He even felt a bit of a conflict there because he said on occasion—I believe it's Woods, Gordon he works for, or he has a substantial influence in it anyway—the health council is examining reports prepared by his own company. So they advise one day, they consult the next, they advise the minister the next, and when the minister wants to check that out, he goes to a health council and they are there, or to the Ontario Council of Health and they are there, and they are all talking to themselves. It's difficult for the world at large to break into that system.

It is something that is noted in Taylor's book, as he goes through. There are two edges to it, and we discussed that at some length in the hearing on the agency this fall. There is clearly some advantage in using a certain amount of expertise around them and there is no question that that expertise is somewhat limited in scope; there aren't that many people around with that kind of experience.

The danger is, of course, that they keep talking to themselves; that they don't hear an outside source; that they hear what they want to hear; that they develop a certain line. Then, if they were consulting in that field one day and advising the minister the next, you will see slowly but surely that the checks and balances system doesn't work, because they are checking with the same people all the time.

It's as if I took Mr. Cooke as the only adviser in the world on anything. We would be right only 95 per cent of the time and we would miss five per cent of the time because we didn't bother to check with other people. It would be that kind of a problem, and in the setting up of the system that's a problem.

Many of us have tried to grapple with how to go to something that is better, how we take the system we now have and move to something which might be preventive in nature, whose structure is somewhat different from what it is now. Frankly I don't think my party, certainly me, were proposing simplistic or radical solutions to the thing. As a matter of fact, I can't think of anything you could suggest in the field of health care as an alternative form of delivery that isn't around somewhere in Ontario. We are at that point now where we are really discussing priorities and degrees and amounts. I am a believer in kind of a community clinic model; the government calls these HSOs. They are around. Again, like everybody else, they are having financial problems. The gov-

ernment is investigating and will report later, I am sure.

A number of people in the party have said that there ought to be more doctors on salary. It's almost as though no one in the world ever suggested that before. That's an established factor; there are a large number of physicians in this province who basically work on salary, so it's not a new, radical, different idea. A number of general practitioners I know worked very hard to see if the OMA would push for or would accept a salary for general practitioners, and that hasn't happened yet.

We have talked at great length about one serious set of negotiations. Part of the problem we have in Ontario with the funding for doctors in particular is that that process is rather in ill repute; supposedly that negotiating process has been strengthened and we will see what comes out of that this year. But there are just a large number of physicians—I would say perhaps the majority, though it probably isn't as accurate as I'd like it to be—who don't really feel bound very much by that set of negotiations.

That's compounded when the Workmen's Compensation Board has its fee-for-service schedule, the OMA has a schedule, OHIP has developed a schedule, and there are a couple of others around as well. The fee-for-service thing as a method of payment, in my view, has some limits to it. I can understand that you set out a fee for service in certain sets of circumstances, but I want to see an expansion of alternatives to that, and the alternatives are in place now in Ontario.

[4:30]

A capitation system is not new to this province. We have it. A salaries system is not new to this province. We have it. Almost any variety of funding for doctors, for clinics, for hospitals, has been tried or is around. So it's not as though you have to lock the family in the basement to weather this storm; these are not radical notions. You don't have to get the 12-gauge and go to the barricades right away. These things occur here now.

I get a little upset when the minister or when other people react so violently to words. It bothers me somewhat that people I assume to be so well educated, urbane, sophisticated folk get upset over words. I know physicians, friends of mine in fact, who will fall over dead if you accuse them of participating in a medicare program. "Oh no," they say, "I don't do that." Semantics are important, that's true, but not important enough to evoke that kind of a response. There are those who say, "I'll never be a



civil servant," and yet all of their pay cheques are from the government of Ontario.

I fail to detect the major difference in tone that's there, that somehow the retention of the fee-for-service system, though they will complain loud and long about its administrative problems, stops them from being recipients of government cheques. I think the thing that would upset them most of all would be to stop those cheques; then they'd really be upset.

There is such a variety of problems as to boggle the mind from time to time; where do you go from here, I think is the interesting problem. I see some movement. I see the minister has responded to the hearings this committee held in the spring, has certainly acknowledged that there is a difference between a hospital in Hornepayne or Smooth Rock Falls and the Toronto General; I think he always knew that. I think he also knew that his funding formulas didn't work particularly across the board, that they might apply in some cases but they don't apply in all, and I see that he has made some adjustment to that.

I see some change in the negotiations with the doctors this time around. I don't know whether that will be good or bad. As someone who has been involved in a reasonable amount of negotiations, I wouldn't be overly pleased with your new system of a changing role for the chairman being the solution to problems in negotiating whatever doctors are paid. I think it's clear, though, that we are going to have to move to a system which says there is one set of fees negotiated; and there is an agency there at the OMA that does that kind of negotiating.

You can alter the negotiating process itself—it needs to be done, I think, in some cases—but once you arrive at that, once you arrive at a fee-for-service schedule, or a salary range, or you work out salary options, or you work to a capitation system, or you go to a roster system, or whatever variety of funding formulas you want to use to provide doctors with a reasonable form of payment, that's fine but you had better clear that up in short order because that is a continuing problem and one I anticipate is getting more and more serious.

I think it goes back to the kind of philosophical differences that were identified by Malcolm Taylor in his book, that there is a certain level of paranoia in all parts that creeps out in this, and what happens with the rhetoric of it all is that it isn't that difficult to get all sides painted into very separate corners, from which there can be no even sensible response, that you are locked into

positions. I think there needs to be established in terms of hospital funding a clear formula and a formula that has some flexibility to it, and one that is open to public scrutiny, so that the public has the right to that.

There is a need to have information about the system, and whether that is how much various specialists, as a general term, are getting. I am not particularly concerned as a politician as to whether we have got some superstars in medicine here. I suppose I can justify paying to a neurosurgeon in Ontario as much money as Harold Ballard pays to Darryl Sittler. I just hope to hell the results are somewhat better. I don't care what an individual makes out of the system; what I do care about is the public's right to know what we are putting into, in average terms, across-the-board medical services and the different kinds of medical services.

I have only about six feet of files for this year's estimates that we are not liable to get through, of disputes and arguments in the profession about who provides the care, and under what supervision, and I don't see much movement to resolve very many of those disputes. I think I would take a simpler view, maybe even a simplistic view, that as long as good care can be provided I am not really concerned about status of the thing.

To point that out, almost every Sunday afternoon when the Argonauts, or any other professional football team is playing, you can witness a remedial act some time during the afternoon in the middle of the field, because there will be a physiotherapist providing primary care without the proper supervision of a doctor and certainly not referred by a doctor. The last time I saw them lug the Argonauts off the field I don't think they even asked for OHIP numbers before they took them to the sidelines and did whatever they do to them.

**Hon. Mr. Timbrell:** They check to make sure whether they are alive.

**Mr. Breaugh:** I can answer that—they are not.

I think there needs to be a reasonable exploration of different modes of funding hospitals. There has to be information available. There has to be an adjustment in the priorities of spending on the part of the government, because that is clearly a problem. There has to be an honest and an open assessment of who can provide care, because part of our problem is perhaps what the Americans are experiencing now. We have managed to control health-care costs in Canada with some degree of efficiency. Americans have not been



able to do that nearly as well as we have. They run about nine point something per cent of the gross national product and we run just over seven, and that has been relatively stable for the last few years.

Americans are in love with the add-on system, where everybody can do all the things they want to do and you simply add on to the system. You give somebody else the key to the wallet.

We have tended not to do that, although I must say I see an imbalance in the system. That is the one I mentioned at the beginning, we have developed high technology medicine in this province to a rather sophisticated degree and we have done so without really going at the basic provision of services.

If you look at what was initially set up as the agency to provide and to monitor basic medical care, the local medical officer of health, the VON, all of those home-service agencies, public, private and combinations of the two that are providing base medical care in a community, there are severe funding restrictions there. One could even say there are labour disputes that have been simmering for a year and a half to two years without any resolution, and I don't see much of a resolution coming.

The ironies that work in the system are things that bother me, the fact that if someone can be in a public hospital we would cover that, or if you are in seven places in Ontario and you need chronic care we will cover that, but if you are in every place else in Ontario—and I understand it is being expanded to 12—you don't cover that.

The reality is that I have people in my riding who are coughing up \$500 and \$600 a month for medical care in their home. That happens here in Ontario. Not everybody is covered by OHIP in Ontario. I now get a regular stream of people who have been fired, laid off, dismissed, never did work anyway, move from one place to another, who wake up one day to find out their OHIP coverage has lapsed. That happens here in Ontario, where I think most of us would assume everybody is covered by OHIP.

**Mr. Conway:** Speak for your self.

**Mr. Breaugh:** So there are serious problems in the system. I wouldn't mind if the minister said, "Yes, I have some problems here. I don't really have all of the solutions. I could use some assistance in arriving at solutions to these problems." I don't hear him saying that.

**Mr. Conway:** He thinks he's the pope.

**Mr. Breaugh:** I wish he was. Even then I would probably disagree with him.

**Hon. Mr. Timbrell:** Moderator.

**Mr. Breaugh:** I read with great interest—to use the model the minister likes to use, the model of district health councils in the Windsor agreement—and I was quite happy when I read the news report of the Windsor agreement. I read what the health council wanted to do. By and large, I was quite supportive of that. However, I must say the last time I visited Windsor, which was two weeks ago, I wasn't that impressed with the results. Frankly, I have to look askance every time I see the minister or the government of the day providing some new service, because I have now learned you have to ask the questions about what new service, and who is getting it.

I would be more than happy to apologize all over the place if the minister can convince me that he is really going to change gears, that he is going to go after preventive care in a substantial way, that what he will do is not simply public relations programs, but in actual fact functioning programs to change the way things are in this province so that we won't have people in this great, wealthy province of Ontario who are not covered by our health insurance plan, that he will recognize the problems that hospitals are having and he will admit that the level of care has dropped. Everybody else is admitting that.

Otherwise, you force us into finding the specific examples, into using documents that I think we have a right to have in the first place. I think you have to open up the information system. I asked questions of the minister in written form last session because I found that the normal source of polite telephone calls weren't really getting the information. I saw questions that took six months to answer. They were less than two lines long and didn't have any information in them. They went to the minister on the Order Paper, they went through his staff, and they got vetted there, and they went to the cabinet office, for some reason, and got vetted there, and then they got back on the Order Paper. They were supposed to be answered in June, we were told, within two or three weeks.

Subsequently, I found out that the government felt it couldn't hand those pieces of paper to the clerk's office. For some reason that would be a great violation of parliamentary privilege. I'm darned if I know why that is. But they didn't do it, so they got answered in October. For the kind of answer that was produced it certainly didn't take any staff time. You could have done that on the back of a matchbook cover and sent it across the floor. You could have done it eight

months ago, for the kind of information that came out of it.

So as a critic you sometimes get a little jaded. You get more than frustrated at the system at work. You wonder whether we have a health-care system in Ontario costing \$4.3 billion a year, and who does it serve. Does it serve the patients and the people of Ontario? I thought so. But it's very difficult for them even to find out what's going on in that system, to get facts and figures; to get accurate facts and figures is quite another story, but even to get base ones is tough to do.

I think there are real problems in health care in Ontario. I don't think the state of the art is nearly as good as I'd like to think it should be. I don't sense that very many people are happy in the system. If we could make that judgement, that the public at large is happy and that the people who work in it are reasonably happy and there is a small group of people who aren't happy, that's probably the way things should be. But I can't find anybody, administrator, doctor, nurse, hospital worker and, increasingly, patient, who is satisfied that this expensive system, that I certainly support, functions well. When I see a minister who isn't even prepared to admit that there are problems, let alone solutions, then I get concerned.

I want to cut my remarks short, because we have a problem with the estimates this year, all kinds of materials that needs to be put out and answered, and I'd like some of those, and I think maybe we could take the last hour this afternoon to see if we could get some of those out, and then the minister could reply to that.

**Mr. Acting Chairman:** Thank you, Mr. Breaugh. Anybody else? Mr. Conway, do you have something to say?

**Mr. Conway:** Mr. Breaugh's remarks ended rather surprisingly. I thought that there was some understanding that, Michael, you were going to—

**Mr. Breaugh:** You don't want to talk?

**Mr. Conway:** I just wanted to be clear that we understood one another. I thought that when you began about an hour ago the understanding was that you would complete your remarks today and the minister would respond tomorrow.

**Hon. Mr. Timbrell:** What I understood was that Mr. Breaugh would complete his opening remarks today and that there might be some other members who had points they wanted to raise by way of questions, and then tomorrow—and that's why I let a number of

the staff go—I would begin by responding to you, and to Mr. Breaugh, and to whom-ever else raises whatever other points.

**Mr. Breaugh:** That was my understanding. I wanted to leave about an hour this afternoon so that people could put in questions.

**Mr. Acting Chairman:** That was my understanding of the situation.

**Mr. Breaugh:** If you want, I can go on for another hour easily.

**Mr. Conway:** I was just taken a bit by surprise, because I had thought that was the agreement, that you would finish with your remarks, such as they were, and the minister would respond. If you say that it's now the intention, Mr. Chairman, to go item by item, we can proceed on that basis, that's no problem at all.

[4:45]

**Mr. Acting Chairman:** I think that was the understanding.

**Mr. Breaugh:** I think it is going to be awkward to do it item by item.

**Hon. Mr. Timbrell:** I thought we were just going to do everything—

**Mr. Breaugh:** If we had two weeks to do this, we could go item by item. In two days it is going to be tough. You start out item by item, but you will be going back to the vote number.

I have lots of other material that I would like to get on the record.

**Mr. Acting Chairman:** Does anybody else have anything to bring up?

**Mr. O'Neil:** Are you talking about any item, any questions concerning your own riding or—

**Mr. Acting Chairman:** That's right. Go to it. This is the time, and the minister will be available tomorrow to answer all these questions for you.

**Mr. Conway:** Go ahead.

**Mr. O'Neil:** Mr. Minister, when you are giving your answers tomorrow, I have a couple of questions concerning my own riding. I made a request quite a while ago to you, sir, and also to people in your ministry about a nursing home study in the Quinte area. At that time I received a letter—I think it was on October 3—from Bessie Weatherhead, stating:

"I understand that you have been trying to reach me concerning the proposed study of nursing-home beds in Trenton. I had asked that this project be delayed until some work was completed within the ministry. The study can now proceed, once the administrative details are worked out—for example, costs,



composition of the steering committee, et cetera."

There are a few other comments that she made. I wonder if I could have an update on where that stands at the present time, committee-wise, financing, whether we are going to be assisted in the financing and—

**Hon. Mr. Timbrell:** Am I not correct, Mr. O'Neil, that the study in the Belleville area has started?

**Mr. O'Neil:** This would be a combination of Trenton, Belleville, Picton, Hastings county and everything else. I just wanted to get an update on that, where it stands, whether we have been given financing on it for the study and how long you figure it will take.

I also would like to get a comment from you, Mr. Minister, on another matter. It is a real concern, especially in our riding, that the present study they had done a number of years ago shows a surplus of nursing-home beds when actually I believe there is a great shortage in the area. I would like to get your comments as to your feelings and the government's feelings on what they propose to do so that we aren't faced with a real crisis in another five, 10 or 15 years.

**Hon. Mr. Timbrell:** Basically, it comes down to this. I am not sure which study you are referring to, but I suspect any indication of surplus would be looking at the standard of three and a half beds per weighted thousand population as the maximum level. Since February 1978 that has been the minimum level, so that essentially the policy of the future is that where local need studies identify needs at, below or in excess of that 3.5 standard for nursing homes, then they will be approved.

An example, I guess, would be Timmins, where I just this last week announced approval of 28 additional beds—this had been recommended by the local health council—which would bring them to a level, as I recall, in excess of 3.5, but based on an assessment of waiting lists and who is actually where right now in the health-care system, that is what they recommended and it passed the examination by our staff.

**Mr. O'Neil:** One of the other concerns I have is that where you are lumping one large area in, we have had the problem in the last year where I believe we are short of nursing-home beds in the Trenton area itself, so we have the situation where some of the people have had to be placed in the Picton area. It means that it may be a husband in his 70s or even in his 80s who in this one particular case had his wife

placed in Picton and the only way he could go to see her, of course, was to drive that distance.

It has created some hardships. We are quite interested in seeing that this study does go ahead as soon as possible, and that some consideration be given to the Trenton area and this particular case for additional nursing-home beds there.

**Hon. Mr. Timbrell:** Certainly, where the need can be established, we are prepared to do that. I mentioned Timmins. Peterborough recently announced a further 30 beds to go there. A couple of others are in the final stages of their assessment and should be announcing fairly soon.

I will ask someone to get that information from Ms. Weatherhead. As far as I know it is on track, but we will just confirm that.

**Mr. O'Neil:** Another concern I have in the area, and it is sort of ongoing and we have discussed it at different estimates, is financing for the Trenton Memorial Hospital.

I know I spoke to I think it was Colleen Savage in the ministry's office on Friday, and it was mentioned that they had some figures showing there had been additional funding given to the Trenton Memorial Hospital, which we had been after for quite a while—I know they had a shortfall of about \$200,000—that they have arrived at a figure and that the letter was on your desk to be signed. They wouldn't give me the figures until they had talked with the hospital and told the hospital what it was. I would appreciate knowing what those figures are.

**Hon. Mr. Timbrell:** Let me just ask my staff: Has that letter gone out to Trenton? Not yet? Okay.

**Mr. O'Neil:** I understand it is there. I have talked with the hospital and I've been told that the figure is in the vicinity of \$80,500, which would leave them with a shortfall of \$119,500.

**Hon. Mr. Timbrell:** Not according to my book, but—

**Mr. O'Neil:** I'd appreciate anything you could give me on that tomorrow.

**Mr. Acting Chairman:** Are you finished, Mr. O'Neil? Mr. McClellan.

**Mr. McClellan:** Thank you, Mr. Chairman. I'd like to take a few minutes to raise a number of concerns more than specific questions, although there are some questions that I have with respect to care services for the elderly. I'm sure the minister is aware of this, that we have about 10 years to plan and put in place an adequate geriatric-care



system before the march of demography catches up to us. If we don't put into place a community-based care system, a comprehensive community-based care system for the elderly, then we're going to have no choice but to start a crash program of capital construction to build institutions to incarcerate people.

I think the choices are very stark. The difficulty is that I don't see a commitment on the part of anybody within government to the setting out of a blueprint for the development of a comprehensive community-based geriatric care system, let alone implementation. So we have little pieces of a system that are being introduced almost on an ad hoc basis, program by program, community by community, but nowhere is there an overall plan of what our system is going to look like in eight or nine or 10 or 12 years. Nowhere do we understand what the legislative framework is going to be for the program. Nowhere do we understand who is going to be responsible for the co-ordination of this kind of a delivery system. The basic planning doesn't seem to be taking place.

So we have the pilot projects for chronic home care which we applaud and appreciate, but we can't get a commitment on the part of government to extend these on a comprehensive basis to all parts of the province. We can't get an understanding of where these things go once they transcend the pilot-project phase. These questions don't seem to get answered.

We have little bits and pieces of home help, home support service, within the Ministry of Community and Social Services. We have some programs within other ministries, in the Ministry of Community and Social Services, to provide things such as elderly persons' centres.

Again, we're all aware of the total inadequacy of the programs, both in terms of the legislative framework, the funding formulas and that kind of thing. We understand how inadequate they are but we don't have a sense of direction—at least I don't, and I've tried to do a fair amount of work around this area. I still don't have a sense of where the government is going. I don't have a sense of what the mechanisms are to develop the blueprint so that we can come to an understanding of where we are going.

Without going on and on, illustrating sector by sector or community by community, let me just ask Dennis what the vehicle is for developing on a provincial basis an adequate plan for the development of a geriatric-care system within the decade, because that's the

time that's confronting us. A basic question is who's going to do it? Is it going to be the Minister of Health? Is it going to be the Minister of Community and Social Services (Mr. Norton)? Is it going to be something that is the responsibility of each local community through their—what? Through their district health council? I don't know. Is it through their district health council or is it through their municipal social services committee?

The situation at this point is enormously clouded by a confusion in jurisdictional overlap and a lack of responsibility for co-ordinated planning. I don't see this changing, I see Keith Norton dealing with little bits of it. I see you dealing with little bits of it. I see the health councils trying to cope with it on a community basis. There seems to be a good understanding about the problem that is confronting us and we know from other jurisdictions what it is possible to do. So how are we going to do it? What is your own sense of the best way to proceed on this?

**Hon. Mr. Timbrell:** First of all, I don't think anyone would reasonably accept the notion that we should be looking at, say, a ministry of aging or anything like that, because we all recognize of course that when you talk about the problems of aging you're talking about matters that impact on every ministry of the government. Primarily, of course, they impact on two ministries—three really; Housing, Community and Social Services and Health—although the others, all of them, in one way or another have an impact.

Essentially the vehicle will be through the Social Development secretariat.

**Mr. McClellan:** God help us.

**Hon. Mr. Timbrell:** I think we want to be careful though, don't we, to avoid leaving the impression that somebody is going to develop a grand master plan which all the senior citizens are going to follow.

**Mr. McClellan:** You know that's not what I am talking about.

**Hon. Mr. Timbrell:** No, but I think—

**Mr. McClellan:** What we are talking about is meeting need and we know that the need is coming on stream just in terms of the numbers of people who are going to be—

**Hon. Mr. Timbrell:** Let's take a "for instance." In most parts of the province today, in terms of health-care delivery the health councils—or where they don't exist, bodies like the health science committees—are undertaking needs assessments in their communities. We also have in the last year received

a variety of proposals from the council of health's task force on aging which Dr. Rose chaired—

**Mr. McClellan:** Yes.

**Hon. Mr. Timbrell:** —and which I take it you have had a chance to look at.

**Mr. McClellan:** No.

**Hon. Mr. Timbrell:** I thought I saw it on your desk there.

As far as the overall co-ordination within the government is concerned, and I would argue that we have made some good progress, it will come through the auspices of the cabinet committee on social development.

At the local level, you are right, we are going to have to depend more and more on the health councils to balance the various demands and the ways of addressing them in their communities. Those health councils are going to have to involve themselves, and some of them are doing this more and more now, with the social service sector in their communities, with the volunteer sector, which has a great deal of involvement with the elderly.

You're not going to have a ministry because it's not feasible. A secretariat within the secretariat I suppose is always possible, but ultimately it will fall on the ministers who form the social development committee to work to ensure that policies with respect to housing are consistent and that policies with respect to support services—you are right, some services exist in ComSoc but most of them would be in Health—are consistent. That's the vehicle for it.

**Mr. McClellan:** We are going to run into enormous problems unless somebody sits down and tries to cut through the Gordian knot. It's an area that's analogous to—

**Hon. Mr. Timbrell:** Some people have. Dr. Rose's task force certainly cut through—

**Mr. McClellan:** Analogous to children's services.

**Hon. Mr. Timbrell:** I don't know that that's feasible. With all respect, I think if you really think about it, I don't know that that is feasible with respect to the elderly.

[5:00]

But certainly Dr. Rose's task force I think cut through a lot of Gordian knots, as you call them, and came out with some practical suggestions, many of which are already being worked on. Through the provincial lottery we have set aside money to found an institute on aging in the province; it'll be the first of its kind in Canada. Somebody made an accurate observation last week that, obviously,

we had a long way to go. We haven't yet any chairs in Canada on geriatrics and gerontology. Even in the short time I have been in the ministry I have witnessed a change in attitude about the care of the elderly. It was not one of those areas the medical profession set out to go into. Family practice, or nuclear medicine, or neurology, or whatever, was more attractive. You get more "highs," I guess, out of that than looking after people who are chronically ill on a long-term basis. I guess that's understandable, but the need is being recognized more and more and we are seeing people like Dr. Fisher up at Sunnybrook who does just a tremendous job in K-wing for the veterans, becoming leaders and being followed.

**Mr. McClellan:** We experienced the same kind of influence when we were in Ottawa. A geriatric specialist who had recently moved into the community was able to start extending his own expertise and influence within the profession in his own community.

Again, that is a reflection of how valuable it is to have people like Dr. Fisher and this doctor in Ottawa. But it also reflects how far we have to go, because even people in the medical profession haven't been, as you say, sensitive to the kinds of things that can be done in terms of rehabilitative medicine for the elderly within our chronic institutions.

**Hon. Mr. Timbrell:** I think there is one other point too. It almost goes without saying, but the real advances in the quality of health care over the next 25 years are going to come, not so much from bricks and mortar and professionals, but from the individual decisions of people who today may be in their 30s or 40s. And they will be the senior citizens of the year 2000 and beyond. And they will make decisions about diet, exercise, drink, smoking and the like which will have an environmental kind of—

**Mr. McClellan:** That's true, but I think it's absolutely certain, and I don't want to belabour it, if we don't have a comprehensive community-based care system in place and functioning and adequately funded and staffed within about 10 years, then we are going to start building the kinds of institutions we are saying we don't need and are undesirable and destructive of human values.

We know we don't have to put people into institutions. We can provide home-support services so people can stay in their own communities rather than go early into nursing homes or chronic facilities. But it's a system that can't be put into place like that, as you well know. It's something that will have to be developed over a prolonged period of



time. And part of the process is just the kind of expertise you've alluded to; the doctor at Sunnybrook and his influence within his sphere of contacts.

If the process isn't given an enormously high priority now, and the legislation to support services on a coherent basis isn't introduced and developed, and the administration isn't established and the structures to co-ordinate service aren't put in place, then we won't have any choice. We can't put that system into place in the course of a year or two years or three years. It's going to take a long time to develop it in each little community across this province. And if we don't have the system in place, as I say again, we will build institutions and we will have another crash program of building brick and mortar facilities, nursing homes, chronic-care hospitals and all kinds of things that none of us want to see.

**Hon. Mr. Timbrell:** I think though, it's not as if we are starting from zero. In the last 10 years, I understand that the average age for people in homes for the aged has advanced significantly.

I sat on the board of the home for the aged in my own area for quite a few years and that says to me that somehow we are keeping people in the community, in their own homes or in family homes longer before there's a need for them to go into homes for the aged. In fact, I am told it is not uncommon now, in many municipalities, to have vacancies in senior citizens' apartments and homes for the aged while we are experiencing pressures in the extended-care units and in the chronic-care units. People are living longer. In fact in the 1970s, the average life expectancy in Canada went ahead by a full year, in one decade.

No we have got to be doing something right.

**Mr. McClellan:** People are living longer.

**Hon. Mr. Timbrell:** That's what I mean. There has to be something right about the whole health and social services system if, in one decade, we can advance the average life expectancy of our population by a full year.

**Mr. O'Neil:** Nobody is disputing the fact that people are living longer.

Let me ask a couple of specific questions. We are still waiting for some initiatives from you. Very specifically, where is the new Nursing Homes Act and regulations? Is it going to be introduced this fall?

**Hon. Mr. Timbrell:** Yes, it should be this fall.

**Mr. McClellan:** Do you expect to introduce it as—

**Hon. Mr. Timbrell:** No, it's not a new act. It's the new regulations.

**Mr. McClellan:** Just the regulations and they will be—

**Mr. Cooke:** What about the amendments to the Nursing Homes Act?

**Mr. McClellan:** I thought they were amendments to the act.

**Hon. Mr. Timbrell:** We weren't looking at amendments to the act.

**Mr. Cooke:** That blue book?

**Hon. Mr. Timbrell:** That was the regulations.

**Mr. McClellan:** So they will be promulgated this fall or what?

**Hon. Mr. Timbrell:** I expect so. I referred to it today in my remarks to the Nursing Home Association annual meeting. The three particular areas we are looking at are in the three areas of administration, accreditation and to back up the move towards accreditation in the nursing homes in the areas of fire and safety.

**Mr. McClellan:** Do you have an implementation target at this point? Can you tell us when you expect those regulations to be enforced?

**Hon. Mr. Timbrell:** It should be by the end of the calendar year.

**Mr. McClellan:** Enforced?

**Hon. Mr. Timbrell:** Yes.

**Mr. McClellan:** Are there any initiatives for rest homes and homes for special care? Let's deal first with homes for special care because that's an area of long standing concern.

**Hon. Mr. Timbrell:** We are taking a look within the ministry at our homes for special care program regarding backup support services. There's a home for special care program and it began in 1964 I think, or 1965. It was essentially a program of residential care. More and more, in a number of communities, new programs have developed that relate to the residents of homes for special care. Clearly, I think we need to develop a plan. We are working on this so, in the long term, those people in a home for special care who need some ongoing activity program in the community get it.

We have had a big expansion in the last couple of years in community mental health programs. This year alone there were a number of programs we supported. We have jumped by about 50 per cent I guess. That



isn't to say we couldn't do more. Obviously we could.

Rest homes, as you know, are like boarding homes, subject to regulation under the Public Health Act by the local municipalities, usually through their boards of health. Some do that well; some do it poorly. We are taking a look at that matter and I will likely make some comments on that on Thursday during the debate.

**Mr. McClellan:** I think probably Richard Johnston wanted to have some discussion about the Metro situation. He will probably be in to do that tomorrow. He wasn't able to be here today so let's set this down.

**Hon. Mr. Timbrell:** On the Metro situation, as you know the discussion paper has been developed. I went out last Thursday as a matter of fact and spent half the day, after opening the East General addition, visiting boarding homes throughout the west end, unannounced, with an old friend of mine who is an alderman in the city and interested in the issue. It was rather interesting; not at all what either of us expected, I think.

**Mr. McClellan:** Just one more thing—

**Mr. Cooke:** Before you get off the rest home thing, when I first came here in 1977, Margaret Birch was talking about what initiatives you people were taking and looking at regulation. ComSoc has been looking at it, I understand.

**Hon. Mr. Timbrell:** I don't think anybody was ever looking at provincial regulation of rest homes because you're not talking about people in need of care. We're talking about nursing homes or homes for the aged, where people are under care.

**Mr. Cooke:** If your premise is that you're talking about people who aren't in need of care, maybe that's your first wrong premise. At least in the rest homes I visited in Windsor they're in need of care. There are psychiatric patients, mentally retarded people and elderly people who can't take care of themselves. If they can't take care of themselves, they obviously need care. If they could take care of themselves they would be at home.

**Hon. Mr. Timbrell:** When I go through hospitals I usually rely on a doctor to make those judgements. I don't presume to make them myself.

**Mr. Cooke:** When ex-psychiatric patients go in for outpatient treatment I assume they still need outpatient care.

**Hon. Mr. Timbrell:** What if they live in their own home? What if my neighbour and some people in my community go for out-

patient care but they're living in their own homes?

**Mr. Cooke:** They can handle it on their own. The people who are in the rest homes can't handle it on their own and that's why they're in rest homes.

**Hon. Mr. Timbrell:** Maybe they don't have one.

What I worry about, as I said to this city alderman, is that when you—

**Mr. McClellan:** We all know who it is.

**Hon. Mr. Timbrell:** It's my old friend Mr. Cressy. We were on several committees on drug abuse a number of years ago.

What I worry about is once a person is discharged, I don't care whether it's from a psychiatric hospital or from a general hospital, someone has made the decision that they are well enough to be back in the community without direct supervision. I think we have to be careful that we don't end up reinstitutionalizing them, but in a different way.

**Mr. Cooke:** I agree with that, but on the other hand in the last two years we've had three incidents in rest homes in Windsor where people have died. A mentally retarded girl went out on an ice floe in the Detroit River from a rest home and froze to death. Another two ex-psychiatric patients who were at that rest home committed suicide. Those people were in need of care and they weren't getting any kind of supervision or adequate care at the rest home because there's no regulation. The regulation in Windsor, the bylaw, is simply square feet and fire regulations. There's no kind of regulation dealing with proper programming or staffing.

**Hon. Mr. Timbrell:** I guess it comes back to this: if the person is in need of care there are ways to get that person to care. As you know in the case of mental illness it's possible, through the police, or justice of the peace, or a family doctor, to get the person to care. If the person needed care, they probably should have been somewhere else, not necessarily in a rest home.

**Mr. Cooke:** Who takes care of getting them to that somewhere else?

**Hon. Mr. Timbrell:** Who takes care of getting them out of private homes? Who takes care of getting you or me out of a private home if we need care? There are ways to do it: the Mental Incompetency Act, the Mental Health Act, and the Public Health Act.

**Mr. Cooke:** You mean an individual is supposed to do that himself?

**Hon. Mr. Timbrell:** No, families can do that. Authorities who are made aware of a problem by people like yourself or others can do something about it. Institutions aren't always bricks and mortar. We need processes as well—

**Mr. McClellan:** We're coming back full circle.

**Hon. Mr. Timbrell:** —and property standards. When I was on council we developed the first property standard bylaw in our municipality in the early 1970s. Most municipalities were into this. Clearly, we accepted that North York had and has a responsibility to oversee the property standards; the conditions under which private citizens were living in private homes. A boarding home is a private home, in my mind. It is not an institution. It is not a health-care facility, as is a nursing home or a home for special care, or a home for the aged under ComSoc legislation.

**Mr. Cooke:** Rest homes are different from that. We don't have the boarding homes in Windsor they have in Toronto. We don't have that problem and I'm not as familiar with it. Rest homes do not provide as intensive a type of care as nursing homes. That's evidenced by the number of nursing homes that, when the new Nursing Home Act came in, changed from nursing homes to rest homes. We know that happened. That happened to a number of nursing homes in Windsor. I assume it happened all across the province.

[5:15]

**Hon. Mr. Timbrell:** Mind you, the new act came in at the same time as the extended-care benefit; the minimum of 90 minutes nursing a day. So, the nursing homes ended up taking over the heavy loads.

**Mr. Cooke:** You take a look at Central Park Lodge in my riding which is, certainly, not your typical rest home. It's more like a hotel. I wrote a letter to you indicating that they had fired all their RNs and replaced them with RNAs. The RNs were obviously upset. You looked at some of the residents who were there, to see if any of them were in need of nursing care, because they probably should have been in extended care, and you said they weren't. But a number of them are having to pay a private nurse to come in and look after them. If they're paying for a private nurse to come in and visit them on a regular basis, I assume they're in need of some kind of care that should be regulated.

**Hon. Mr. Timbrell:** That same person, obviously, would have a physician in the

community who could make an assessment in 20 minutes to half an hour as to whether or not they qualified for extended care. The physician would fill out the necessary forms and apply for them.

**Mr. Cooke:** But the individual doesn't want to go into a nursing home because the individual thinks that Central Park Lodge is a very nice place. What I'm saying is that if Central Park Lodge is going to offer that kind of service then they should be properly licensed and regulated.

**Hon. Mr. Timbrell:** In the act, the definition of a nursing home is clearly set out, and most municipalities have a clear definition of what they consider to be a nursing home or a caring facility. So any facility that presumes to offer a program of care that would come under that definition has to conform to the Nursing Home Act. It has to be licensed under the act, subject to inspection and so forth. Anything else really falls into the category of a private facility, a private home and, like your home or mine, is subject to the provisions of the Public Health Act.

In any review we've done, we don't feel that many, if any, municipalities have really used the full authority available to them under the Public Health Act and the Municipal Act to set standards for boarding homes and rest homes.

**Mr. Cooke:** And why should they? If they pass that kind of a bylaw they're going to have to enforce it and pay for the enforcement through property taxes.

**Hon. Mr. Timbrell:** Just as they have to pay for property standards bylaws for the single-family house next door to you.

**Mr. Cooke:** It shouldn't be just property standards.

**Hon. Mr. Timbrell:** It isn't. The fact of the matter is it gets into that same gender of property standards.

**Mr. Cooke:** But you're talking about programming and quality of care and something the municipality would have to do. You'd need a whole different direction to do that kind of inspection.

**Hon. Mr. Timbrell:** No, they wouldn't.

**Mr. Cooke:** That's something the provincial government should be doing on a province-wide basis.

**Hon. Mr. Timbrell:** If we're talking about people who need to be under regular medical or nursing supervision then they probably shouldn't be in a rest home in the first place.

**Mr. Cooke:** We're talking about people who don't necessarily need that type of intensive care, but who need care.

**Hon. Mr. Timbrell:** That's an assessment that should be made, not by politicians, but by qualified medical personnel, or public health personnel.

The net result, with respect to what you're suggesting, is institutionalizing people whom the professionals have decided don't need to be institutionalized any longer.

**Mr. Cooke:** Next time you're in Windsor I'll take you to some of the rest homes, if you've got a couple of hours. You can tell me whether those are institutions or not. They are institutions, but the problem is they're institutions that aren't regulated properly and, in some cases, are filthy and, in some cases, people are getting very poor care.

**Hon. Mr. Timbrell:** You keep coming back to the question of care. I'm saying if they require care—

**Mr. Cooke:** They're there. They need some kind of care. There are no nursing homes. Even if they did qualify for a nursing home there are no nursing-home beds in the county of Essex.

**Hon. Mr. Timbrell:** Sixty just opened in the adjacent county and there's a study under way.

**Mr. Cooke:** In Kent county 60 beds just opened. If 60 beds opened in Kent county I assume they're to serve Kent county not Essex county. Do we have to travel from Windsor to bring relatives back to visit?

**Hon. Mr. Timbrell:** You've got a needs assessment under way in your own health council.

**Mr. Cooke:** They've been recommending beds to you for quite some time. What I'm saying is that these rest homes are providing a certain type of care but they're not up to any kind of standard. There are a number of people on welfare in those places and the per diem is paid for by welfare. You take a look at where those people are placed. Those who are on welfare and can't afford to pay their own per diem don't go to Central Park Lodge. They go to the old nursing homes that were closed down as nursing homes but have been converted into rest homes and barely meet the standards given in the rest home bylaw in Windsor. So, if you can afford it, you can go to a good rest home; if you can't afford it, you go to the crummy ones.

**Hon. Mr. Timbrell:** Have you ever actually sat down and asked the legal counsel for the

city, the medical officer of health and others to do an assessment of your existing rest homes cum boarding homes bylaws?

**Mr. Cooke:** Social planning just did one and they recommended province-wide regulation.

**Hon. Mr. Timbrell:** That's not the answer.

**Mr. McClellan:** That's not the answer you wanted to hear.

**Mr. Cooke:** Dr. Jones from the Essex Medical Health Unit has also recommended that there be provincial regulation.

**Hon. Mr. Timbrell:** I think that if we're going to be talking about—

**Mr. Cooke:** Better regulation, by the way, than nursing homes, he suggested, if we're not satisfied with the kind of reports you do on nursing homes.

**Hon. Mr. Timbrell:** Well I'll have to look up and see what specific recommendations he's made over the years on nursing homes. I don't think there have been many. Where care is involved, nursing homes, homes for the aged, clearly, we have accepted that that is a provincial matter.

Where it's a matter of residential standards, then that's something else again. If somebody in a residential setting needs care, then that's something for a physician to decide. Then, we have to try to make sure that there are programs or facilities available to look after the person who needs care. And I make that kind of a distinction.

**Mr. Cooke:** Can I ask you one thing? I've stolen the mike from Ross.

**Mr. Acting Chairman:** I'm going to take it away from you in a minute, Mr. Cooke. We have a few more questions.

**Mr. Cooke:** Okay. When you inspect nursing homes, and the latest one I asked you to inspect, the Riverside Nursing Home, why do you not bother to talk to staff and residents? Why do you just talk to the administrator and the head of nursing?

**Hon. Mr. Timbrell:** No. If you look at that report I sent you, I'll be glad to—

**Mr. Cooke:** Oh, I read it.

**Hon. Mr. Timbrell:** They did talk to staff. They did talk to residents.

**Mr. Cooke:** According to the report I read, they talked to the head nurse and the administrator.

**Hon. Mr. Timbrell:** No, if you look at each one individually, they've talked to staff and residents.

**Mr. Cooke:** They didn't talk to the individual who made the complaint.



**Hon. Mr. Timbrell:** If you like, I'll get the report.

**Mr. Cooke:** I've got it. I talked to the woman who made the complaint, Mrs. Dietrich, afterwards. In my letter to you, I offered to arrange meetings with the staff who did not want their names mentioned, but were willing to come to a confidential meeting with ministry staff in order to talk about the problems. They're worried about their jobs, obviously. No one ever contacted me. Those meetings were never arranged.

**Hon. Mr. Timbrell:** Well, case number one, they talked to the administrator, director of nursing, the registered nurse in the emergency department of Hotel Dieu Hospital, the attending physician. Then they went over the notes made by the nurses and the doctors.

**Mr. Cooke:** I read that.

**Hon. Mr. Timbrell:** Case number two, they talked to the administrator and the director of nursing, again, an RN in the emergency department of Hotel Dieu, and the attending psychiatrist.

**Mr. Cooke:** That's not what I asked you, though. I asked why you did not talk to the dissatisfied staff of the nursing home who were willing to come to a private meeting with your inspectors. I said, very clearly, that I would arrange the meeting.

**Hon. Mr. Timbrell:** You don't accept that a psychiatrist, or a doctor, has responsibility?

**Mr. Cooke:** I don't accept that they know what's going on in the nursing home, that's right. They're not in the nursing home 24 hours a day like the staff is. A psychiatrist obviously is not in a nursing home 24 hours a day. These people have volunteered to talk to your inspectors. I'm simply asking you why you didn't take up their offer. Will you take up their offer? I wrote you a followup letter last week. It makes me wonder.

**Hon. Mr. Timbrell:** First of all, I don't know why you object to us talking to the physician who's responsible for the person's care.

**Mr. Cooke:** I'm not objecting to that. I'm saying in addition to that you should have talked with the dissatisfied staff. You should have arranged that through me. I'm willing to do it. The staff who still work there obviously would not allow me to use their names in a letter to you, because they're worried about their jobs. Ten to 15 staff members have been fired in the last year and a half because of various things. Some of them because they complained to the administration. At least that's their impression.

**Hon. Mr. Timbrell:** I'll wait until I see what your latest open letter says.

**Mr. Cooke:** No, it's not an open letter; it's a letter to you.

**Hon. Mr. Timbrell:** Why?

**Mr. Cooke:** Because it says the same thing as before. You never respond to them.

**Hon. Mr. Timbrell:** I'm sorry, but I do. You just don't like it when I respond and your allegations aren't found to be substantiated by the inspectors.

**Mr. Breugh:** How could you conduct an investigation without at least having the staff talk to the person who complained?

**Hon. Mr. Timbrell:** I sent people away because of our agreement earlier that we would respond tomorrow, but I recall that the lady in question did contact the branch several days before your allegations were made by way of an open letter, using patients' names.

**Mr. Cooke:** I did not use patients' names in the copy that went to the press.

**Hon. Mr. Timbrell:** Okay, well, that's improvement. That's improvement.

**Mr. Grande:** There you go, doing it again.

**Mr. Cooke:** Maybe you can explain, improvement over what?

**Hon. Mr. Timbrell:** Improvement over bandying people's names around.

**Mr. Cooke:** I use patients' names and individuals' names on the OHIP and on the doctors opting out when the individuals either encourage me to, or give me permission to use their names. I don't give me throwing people's names out unless I've had their permission.

**Hon. Mr. Timbrell:** And encouragement is permission?

**Mr. Cooke:** That's right. Encouragement on their part to use their names because—

**Hon. Mr. Timbrell:** I'll have somebody here from inspection tomorrow who can talk in greater detail about that. But the individual did contact the press several days before.

**Mr. Cooke:** Well, the offer still stands. Maybe you can take a look at it, and get back to me tomorrow.

**Hon. Mr. Timbrell:** And I'll be glad to take a look at your latest letter, to see what additional information you've got.

**Mr. Cooke:** There's no additional information, other than that it's interesting that the owner of the nursing home is such a prominent member of your party, and donates so heavily to your party—

**Hon. Mr. Timbrell:** Mr. Chairman—

**Mr. Cooke:** —that it makes me wonder why you don't want to investigate that nursing home.

**Hon. Mr. Timbrell:** Mr. Chairman, that kind of remark is utterly unbefitting of a member of the House.

**Mr. Cooke:** I can't understand any other reason why—

**Hon. Mr. Timbrell:** Every time you've complained, justified or not, that nursing home has been thoroughly inspected. When you make that kind of a ridiculous, asinine remark, you call into doubt the integrity of all of my inspection staff and I think you owe an apology, because it is totally unwarranted.

**Mr. Cooke:** Show me the inspector's report and then maybe I will. I don't get the inspector's report in any case.

**Hon. Mr. Timbrell:** You've got the report that came to me—

**Mr. Cooke:** That's a summary of the report. That's not the inspector's report to you.

**Hon. Mr. Timbrell:** Well, Mr. Chairman, really, I think this member tries the patience of a Job.

**Mr. Breaugh:** Well, how the hell do you conduct an investigation without talking to the person who laid the complaint? How do you do that? How does anybody do that, ever, anywhere?

**Hon. Mr. Timbrell:** Calm down.

**Mr. Breaugh:** I'll calm down when I feel like it. How do you?

**Hon. Mr. Timbrell:** Well, if you don't feel like it that's your problem.

**Mr. Breaugh:** That's right. How do you? How do you conduct an investigation without asking the complainant?

**Hon. Mr. Timbrell:** I'm trying to answer the comment the member from Windsor made.

**Mr. Breaugh:** You've got selective hearing today, just like every other day.

**Mr. Acting Chairman:** Let the minister reply, and then—

**Mr. Breaugh:** I've been waiting eight months for this guy to reply.

**Hon. Mr. Timbrell:** That kind of comment is totally unbefitting a member of this House.

**Mr. Breaugh:** And that kind of a comment is totally unbefitting a minister. You were asked a question. Try and answer for a change.

**Mr. O'Neil:** Mr. Chairman, why don't we go on?

**Mr. Acting Chairman:** We have several other names. Mr. Ramsay, you wanted to ask some questions.

**Mr. Cooke:** I don't know why you should be so sensitive about that.

**Mr. Ramsay:** I'll wait for Mr. McClellan, if you wish.

**Mr. McClellan:** No, I've taken enough time. Go ahead.

**Mr. Ramsay:** I guess the terms of reference, Mr. Chairman, have swung a bit. I understand we were just going to ask questions and the debate or the responses would be tomorrow. Nevertheless, the main thrust of what I had to say has already been said by Mr. McClellan.

I wanted to be sure that we got some input and some information on the planning for the elderly and programs for the elderly and Mr. McClellan has gone into that in detail. I won't go over it again.

Interjection.

**Mr. Ramsay:** I was waiting for the answers tomorrow.

**Mr. McClellan:** Maybe we'll have an answer tomorrow.

**Mr. Ramsay:** The other things I wanted to put on the Order Paper, so to speak: I sat on the administration of justice committee studying the amalgamation of the Ministries of Education and Colleges and Universities during September. One of the issues discussed was the funding of research in our universities. I think that's a subject that probably relates as much to the Ministry of Health as it does to the Ministry of Education. I'd like to hear some comments on that.

I suppose this is available if I researched it, but I also hear that the provincial lottery grants are funding projects and facilities, et cetera. However, I hear it in a piecemeal fashion. I'd like a summary of what has happened in this respect, and what the future plans are for the provincial lottery grants as far as health is concerned.

The last point I'd like some input on is the mental-health programs. I'm not referring here to the psychiatric hospitals. We went through that in great depth with Queen Street and Lakeshore in the spring. I'm talking about the overall mental-health programs for the province and in particular for northern Ontario, where we don't have the institutionalization that you have here in southern Ontario.

Those are the points I'd like to have a response to tomorrow, or whenever the minister is able to do so.

[5:30]

**Mr. Ruston:** I wonder if the minister could elaborate on the method of operations of the doctors under the medical plan in Quebec, and if the doctors who have opted out are not allowed to bill OHIP—or the patient is not allowed to bill OHIP.

**Hon. Mr. Timbrell:** There are two ways to be opted out in Quebec. You can be opted out entirely and charge in excess of the amount in the schedule of benefits of the Regie, and neither you nor the patient collect. You can be opted out and charge the patient exactly the same as the Regie, and they collect from Quebec City.

**Mr. Ruston:** Yes, as long as he charges the same amount. But if he charges more than the amount the government has agreed upon with the doctors, then he is out—and is it correct that the patient cannot bill—

**Hon. Mr. Timbrell:** That's right. Neither can collect. It's similar to the Saskatchewan system in this respect. In Saskatchewan there are three modes of billing: As a physician, you can bill the MCIC directly; or you can bill a third-party carrier, who will then collect from the MCIC; or you can bill the MCIC and bill the patient an extra amount. About 30 to 40 per cent of the doctors are doing this for some of their claims.

**Mr. Ruston:** Is the rate for an office visit to a general practitioner still \$7.70?

**Hon. Mr. Timbrell:** I can't recall what the exact amount is. That's for a minor assessment. Intermediate assessment is about \$10.

**Mr. Ruston:** I know that's one of the problems we have, but not the only one. We have many specialists who have opted out since, too. I can go back many years to the example of Dr. V. Kleider in Windsor who opted out and his son has moved out. But this was the practice he had, even when Windsor Medical or the Essex County Medical Co-op were in business. He would submit a bill to us and we would pay the Ontario Medical Association rate. In most cases, we paid 100 per cent, depending on the funds available. Sometimes it was 90. But he then would charge some patients—what he called “chosen patients”—over and above the medical association rate.

**Hon. Mr. Timbrell:** Like Saskatchewan.

**Mr. Ruston:** Yes, that's going back to 1965 and 1966.

**Hon. Mr. Timbrell:** They've had it since 1962, when they set up their plan. They brought in the three modes, as they call them. Mode three is the one you're describing, where they would bill the plan and bill the patient.

**Mr. Ruston:** How serious a situation would that be, I wonder, if we had a system in Ontario like that? It probably would mean that in some of the metropolitan cities you would have doctors opting out who would then deal with those who were financially capable of paying all their own medical fees. But it seems to me it would discourage opting out in most other areas.

Of course, I realize the financial part is going to have to be commensurate in order to keep them in. So that's where your problem is now, to some extent.

When the medical profession negotiates, it has appeared to me over a number of years the general practitioners—I suppose they are the weak link of the profession—have suffered more in most cases; not in all.

**Hon. Mr. Timbrell:** The GPs account for about half the membership of the medical association. When the association develops a position on fees, they use their economics committee—I don't know what the membership of that is, but GPs are on it. Their goal is—and this is well known in the negotiating process—to raise the average annual income of a GP to 80 per cent of that of the average specialist. I think going into negotiations the average GP's income was about 78 per cent of the average specialist's income.

**Mr. Ruston:** That seems rather high. You're sure that's 78 per cent?

**Hon. Mr. Timbrell:** That's the number I've got in my mind, I'll check it out. But 80 per cent is certainly the goal they all may have got, in the relationship between the average GP to the average specialist's income. It's interesting, compared to, say, Britain, because in Britain it's the reverse. The GPs in Britain make more, on the average, than the consultants.

**Mr. Ruston:** They work longer hours.

**Mr. McClellan:** Let's go back to the final comment I wanted to make about care for the elderly. We still don't have co-ordinated placement services in most communities in the province. How many communities would have a system like the Hamilton one?

**Hon. Mr. Timbrell:** I can't remember the number. We just set one up in Essex, for instance, on October 1. I can't remember the exact number. I want to say 12. Does that sound right? I'll correct it if I'm wrong.

**Mr. McClellan:** About 12, did you say? As a Metro member, acutely aware of the difficulty that people experience—I'm sure you're familiar with it, but let me just run through the process of what you have to do. I understand the individual has to get a



recommendation from a doctor. You fill out the application form. You send it to the Ministry of Health, and the ministry sends you a certificate of eligibility. That's only the first level of bureaucracy you have to negotiate.

If you don't know what nursing home you want, or where you want to go, you can't get that information from the ministry. You have to go to your municipal social service department and try to get a list of nursing homes that are available. They don't seem to have information about waiting lists, so the assumption at both levels is that the individual knows exactly what he or she wants and needs and is simply applying to get into a particular place.

But if you don't know what the system is, and you don't know the length of waiting periods, in many respects you're out of luck. You're just not able to get a place that meets your needs. There isn't any place where you can get assessed where you can get advice, or the family can get advice. So in a nutshell, when are we going to get a co-ordinated placement service in Metro?

**Hon. Mr. Timbrell:** I would hope that over the next 18 months one can be developed. We've had a couple of places—Hamilton comes to mind—where it's been an assessment and co-ordinating service.

What we're doing in Hamilton is telling them they have to drop the assessment part, because that's a duplication. The assessment is being done in the hospital, or in the nursing home, or in the family physician's office, or whatever, and they just turn around and do it over again. It's a needless duplication—putting people through the hassle of more paper.

The placement co-ordination aspect is the most important. I've gone through this same thing. Just very recently a constituent, an elderly lady trying to look after her 86-year-old sister, had finally come to the point where she couldn't. She had applications all over the place—

**Mr. McClellan:** Why is there a particular difficulty in setting something up in Toronto?

**Hon. Mr. Timbrell:** I think the difficulty is in getting either an existing agency that would take it on, or finding an appropriate agency, or developing an appropriate mechanism. In Metro, it's going to be a very, very large task, as I'm sure you're aware. There are 10,000 hospital beds alone here.

**Mr. Breaugh:** Are you going to be operating them?

**Hon. Mr. Timbrell:** No, we are not. As a matter of fact, in a couple of areas the health

councils have been operating them, and we've told them to divest themselves.

**Mr. Breaugh:** You are suggesting probably to help council would develop some kind of model and make recommendations in some other agency?

**Hon. Mr. Timbrell:** It doesn't necessarily have to wait for the health council.

**Mr. McClellan:** If you hope something will be set up in 18 months, can you tell us what the structure will look like and who will be doing it, or at least what your thinking is at this point in time?

**Hon. Mr. Timbrell:** Let's take over in Hamilton.

**Mr. Breaugh:** No, in Metro. I'm talking about Metro.

**Hon. Mr. Timbrell:** I'm just trying to look for an example to give you because—

**Mr. McClellan:** —you don't know what they do there?

**Hon. Mr. Timbrell:** No, they vary.

**Mr. McClellan:** Sure they do. I want to know what your plans are for Metro. I know how the Hamilton system works, I've used it. I want to know what is happening in Metro.

**Hon. Mr. Timbrell:** Oh, I see. There are no specific plans at this point. They do vary across the province. Some would be operated by VON; some would be operated, as I said, in a couple of communities they have been operated by the district health council. Others operate under the auspices of a hospital.

Now, I can't be any more specific than to say we are hoping to develop—

**Mr. McClellan:** How can you say that you hope to plan to put something in place within 18 months, and then say you don't have a plan? Either you have a plan or you don't.

**Hon. Mr. Timbrell:** If we had a plan we'd do it tomorrow.

**Mr. McClellan:** So you're developing a plan?

**Hon. Mr. Timbrell:** Yes.

**Mr. McClellan:** What is the vehicle for developing the plan?

**Hon. Mr. Timbrell:** Working through our area co-ordinator for Metropolitan Toronto. It's been discussed with the hospital council and HCMT. At this point it's mainly in exploratory stages. We have moved in other areas, where we have specific proposals developed, like Essex. It's been developed, and it was put into place on October 1.

**Mr. McClellan:** I know about Essex, too. Is there a funding problem? What kind of

budget do you anticipate? I'm sure it's not a large budget.

**Hon. Mr. Timbrell:** No, it is not. The one in Essex, if I remember correctly, is something like \$38,000 for the year, which is not, relative to the total scheme of things, a lot of money. That's not a problem.

**Mr. McClellan:** Just a final point, then. When do you expect to be able to give us some details about the Metro placement service—

**Hon. Mr. Timbrell:** I hope within the year. I'd like to see something in place within the next 18 months. We haven't got any firm proposals at this point as to who would do it. To my knowledge, nobody has come forward and offered to take it on. It is going to be an enormous job. We do have to have the commitment of not only just the hospital community, but also the operators of the homes for the aged, and both the private charitables and the municipals and the nursing homes that they will use the service.

Now, for instance over in Halton, the doctors there have taken the position that there is no need for a placement co-ordination service in that region, because they feel that the discharge planning service in the Oakville Trafalgar Memorial Hospital is so good that it obviates the need for a placement co-ordination service. Whether that is ultimately where we will end up, I don't know. Every area is going to be dealt with individually.

A reminder: we have set aside \$150,000 to operate a service in Metro. It's a matter of finding a willing and appropriate mechanism.

**Mr. McClellan:** Just to pick up on your point with respect to assessment. I have to express a certain amount of apprehension if you would take the assessment function out of the service on the assumption that the family physician is in the position to make an adequate assessment. I am just not sure that family physicians have enough sensitivity with respect to geriatric care possibilities, if you understand what I mean.

Let be put it more bluntly. I think the family physicians have not had adequate training with respect to gerontology and that they don't as a group, still acknowledge the potential for many elderly people to remain in their own homes in their own communities with adequate services. There is still too much of a tendency to institutionalize.

**Hon. Mr. Timbrell:** I've got to tell you, most of the letters I get from MPPs are not that doctors have filled out applications for extended care, it is because they haven't

filled them out. They've said this person doesn't need nursing home care, or they can function in their own home. Those are the kinds of letters I get from our colleagues, not the ones that say, "Look, doctor so-and-so assessed this person as requiring institutionalization and I don't think we need it." [5:45]

**Mr. McClellan:** My response to that is basically, "So what?" We talked a little bit, a few minutes ago, about the influence of Dr. Fisher at Sunnybrook and the other gerontologist in Ottawa. A lot of work needs to be done that has not been done yet.

**Hon. Mr. Timbrell:** You can make that kind of generalization about the whole question of hospitalization. If you look at the way in which we use hospitals in Canada compared to other jurisdictions—

**Mr. McClellan:** Yes, but your assessment service—

**Hon. Mr. Timbrell:** Just for example, if you compared—well, Kaiser Permanente is not a good example because that's perhaps an extreme, but where they've got the health maintenance organizations in the United States, their use of hospitals is about half. In fact, it is less than half of the Ontario or overall Canadian rate of hospital utilization. They're no healthier, they're no sicker, they really don't have any different trends of morbidity or mortality, but somehow they have managed to—and I think even your leader recommended this to us last week in his comments when he made the \$800 million suggestion of what could be cut out of hospitals if we all followed the particular course he was talking about. All of us have to take a very close look at the way in which we use hospitals because we do tend to overinstitutionalize our population for all things. That's a well-known, long-known fact.

**Mr. McClellan:** There is really a certain futility around trying to deal with problems with you, Dennis but I'll pursue anyway. I make the point to the chairman, who is a good listener.

The assessment service can have an important planning function in terms of being able to identify shortcomings in the range of service in a particular community, so if you simply throw the assessment service back on to the existing service providers, because the existing service providers still have an institutional bias, you're going to get a distortion in the placement.

Secondly, you lose the opportunity to get an objective assessment of needs from a different perspective, from a different set of biases

or assumptions. But I don't expect you to understand that.

**Hon. Mr. Timbrell:** No, I know your superior intellect in all of these things, but—

**Mr. McClellan:** No, it is just because you are so arrogant that you won't listen or discuss without—

**Hon. Mr. Timbrell:** No, I'm listening, but I think you are starting from a different point.

**Mr. McClellan:** —wanting to be snide.

**Hon. Mr. Timbrell:** First of all, I don't accept that a general practitioner in Canada doesn't have any skills to do an assessment of the needs of his patients.

**Mr. McClellan:** Neither do I. Neither did I say that, sir.

**Hon. Mr. Timbrell:** I think it has been found to be wasteful.

**Mr. McClellan:** But if you want to play cheap political games on the issue, go right ahead. If you want to try to have an intelligent discussion about a real problem that is facing us, that is to say, the institutional bias of our health-care system, which you and I agree exists because we are trying to deal with the problem, then let's cut out the—

**Mr. Breaugh:** There is a word for it but it is not parliamentary.

**Mr. McClellan:** Yes, right. I can't use the word. But I never said what you seem to be claiming that I said. I'm just saying there is a lot of work that needs to be done at the level of the family practitioner in helping them to understand the full range of potential that elderly people are capable of achieving.

**Hon. Mr. Timbrell:** I don't think anybody is disagreeing with that.

**Mr. McClellan:** Fine, good.

**Hon. Mr. Timbrell:** I certainly took what you were saying before to be a suggestion that there was a need for some other assessment process to oversee and be a check or a balance against the family practitioner. That is what I heard you saying before—

**Mr. McClellan:** Yes. Right.

**Hon. Mr. Timbrell:** —and I don't accept that. I don't accept that. I tell you that that has been found to be a wasteful duplication

because if you accept, and I think we both do, that there's a need to broaden the information and attitude about the elderly and the whole aging process, then you are suggesting that you put people in place for the check or the balance that come from the same background as those who are making the first assessment. Overall, I grant you, there's a need for an improvement. The data—

**Mr. McClellan:** It's a question of whether you change or you turn the whole system around.

**Hon. Mr. Timbrell:** Excuse me, may I finish this time?

The data which is generated through the placement co-ordinating services is a very helpful tool to bodies like the health councils. I'm thinking about Ottawa in particular, where they previously ran what was an assessment and placement co-ordinating service. The data has been very helpful to them, especially their long-term care committee, in evaluating their needs for chronic care and extended care. In fact, it played a fundamental role in their report which recommended converting the Ottawa General Hospital to chronic care. The report has been accepted and that project has been given approval.

**Mr. Breaugh:** Just before we end today, could I get my oar in on a couple of specifics so I won't have to ask them tomorrow? Could I ask the minister to respond in some way tomorrow to the rather dramatic increase in the cost of drugs and in the cost of all kinds of other materials used in hospitals? It is a major area of cost and of concern, and it is one in which the whole industry in both sectors, supplies—surgical supplies and everything else—and drugs, is virtually dominated by American industries. It points up an additional problem: When you even look at maintenance of costs now, with the dollar value changing as it is, you're looking at a 15 or 16 per cent increase before you even look at the American supplier jacking up his price.

Some time tomorrow could you respond to that specific question, with your estimation of how serious it is and an indication of anything you might have done?

The committee adjourned at 5:51 p.m.



---

CONTENTS

---

Monday, October 15, 1979

Opening statements, continued: Mr. Breaugh .....	S-851
Adjournment .....	S-874

---

SPEAKERS IN THIS ISSUE

---

Blundy, P.; Acting Chairman (Sarnia L)  
Breaugh, M. (Oshawa NDP)  
Conway, S. (Renfrew North L)  
Cooke, D. (Windsor-Riverside NDP)  
Grande, A. (Oakwood NDP)  
McClellan, R. (Bellwoods NDP)  
O'Neil, H. (Quinte L)  
Ramsay, R. H. (Sault Ste. Marie PC)  
Ruston, R. F. (Essex North L)  
Timbrell, Hon. D. R.; Minister of Health (Don Mills PC)











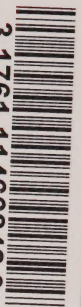
Government  
Publications



BINDING CEST. AUG 26 1980

Government  
Publications





3 1761 11466842 9